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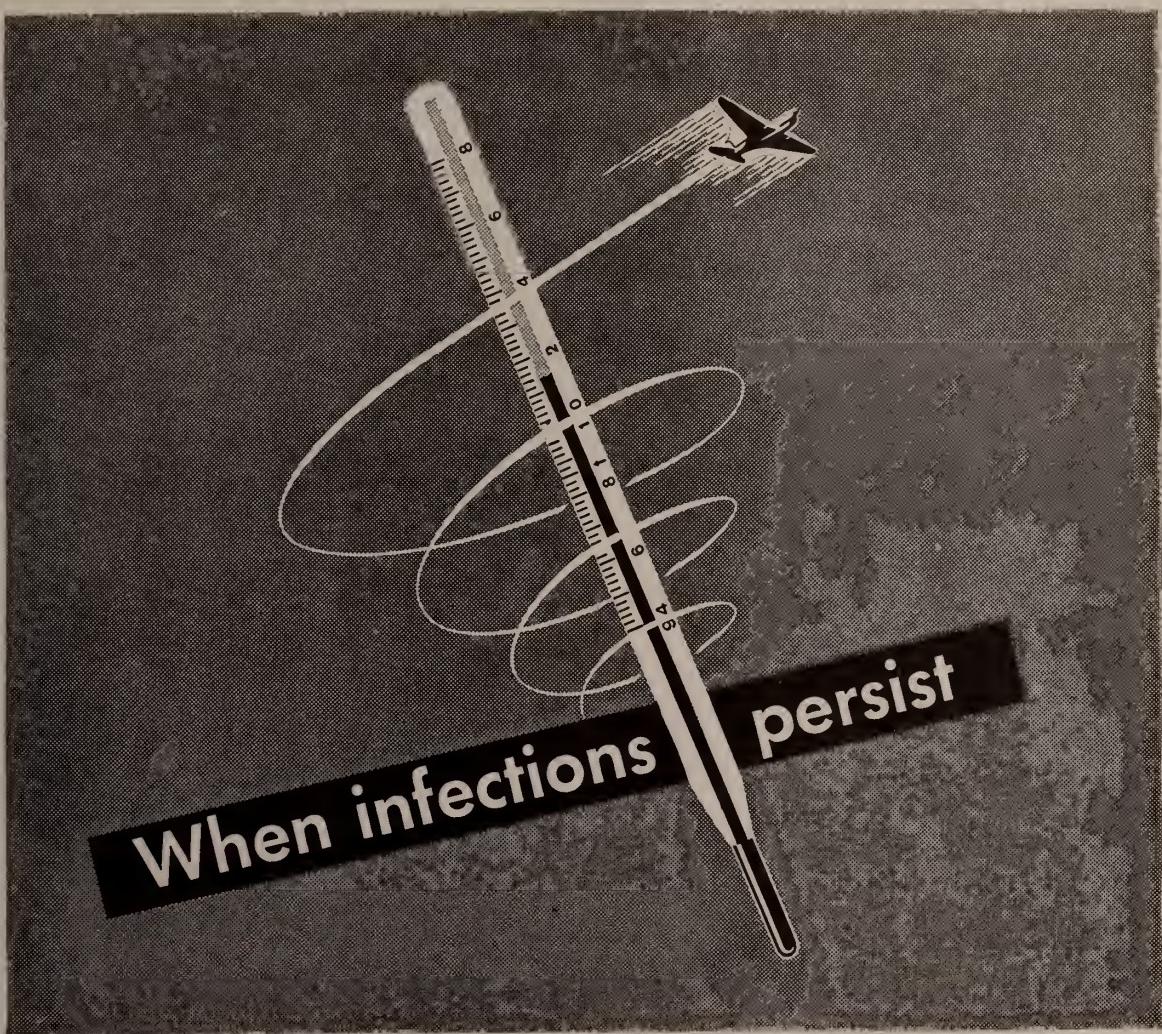
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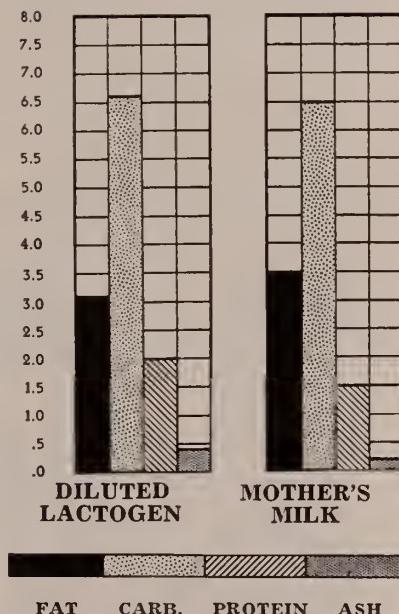


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## THE MANAGEMENT OF URETHRAL STRICTURE

PALMER R. KUNDERT, M.D.  
AND  
LOUIS M. ORR, M.D.

ORLANDO

The proper management of urethral strictures is important in view of the high morbidity and relatively high mortality caused by such lesions. The impairment to health and jeopardy to life are, in most instances, caused by associated infection and damage to the upper portion of the urinary tract. It is, therefore, important that strictures be recognized early, that infection be properly controlled and that renal function be restored to its optimum capacity in order to insure the most favorable prognosis.

Urethral strictures may be classed as congenital, traumatic and inflammatory. Approximately 90 per cent of all strictures belong to the inflammatory group, and most of these are of gonorrhreal origin. Other causes may be tuberculosis, syphilis and chancroid.

The treatment of gonorrhreal strictures may be prophylactic, nonoperative, or operative. The best form of therapy is preventive. Too often the improper care of acute gonorrhreal urethritis has been responsible for the formation of stricture by prolonging the course of the localized infection. The use of cauterizing solutions, too forceful injections and the improper use of instruments must, therefore, be condemned. Because stricture formation is directly proportional to the severity and duration of the localized infection, use of the sulfonamide drugs in acute gonorrhea should prevent the occurrence of this complication to a large extent. To just what extent, only time will provide the answer.

Having failed in preventing a stricture, one should make every effort to restore and maintain a normal urethral caliber. Except in the treatment of strictures of the meatus, which should always be cut, two types of treatment are available. Nonoperative or palliative therapy consists in dilatation. This fosters the absorption of inflammatory exudate, thereby increasing the size of the urethra. It should be regularly and persistently performed. Under this treatment most

strictures can be controlled, but few can be cured. The equipment required for such therapy includes filiforms, Phillips bougies and catheters, Le Fort sounds, woven bougies, steel sounds and dilators. As a rule, it is unwise to use steel sounds smaller than size 18 F to dilate strictures since their sharp points may engage and injure the urethral wall. Occasionally, however, a very tight stricture may be better engaged by the tip of a 12, 14, or 16 F sound than by any other instrument. Such a procedure should be carried out with great care and then only by one especially skilled in its execution.

Unfortunately, most patients, at least for the first time, do not present themselves until the stricture has contracted to such a small caliber that the orifice will admit only a filiform. This instrument may be either of the whalebone or the woven type and varies in size from 3 to 6 F. The woven filiform is preferable as its tip can be set at any desired angle, and it is less apt to injure the urethra. A catheter or woven bougie can be attached to the filiform and serves to guide it into the bladder. The search for the strictured urethral orifice may at times be exasperating and demands the greatest patience. An attempt is first made to pass a single filiform with the tip bent at various angles. Failing this, several filiforms may be used in what is known as a pyramiding procedure whereby the accessory filiforms guide the remaining single filiform successfully through the stricture. Occasionally filling the urethra with lubricant jelly or oil will facilitate the passage of filiforms or bougies. At times it is necessary to administer an opiate or substitute block for local anesthesia before urethral instruments can be successfully passed. Unless there are complications such as periurethral abscess, fever, or complete retention, failure to pass a filiform does not necessarily indicate immediate surgical intervention. The patient may be instructed to return in a day or two, having meanwhile taken hot sitz baths. These frequently facilitate later attempts to pass instruments. In order to prevent embarrassment, a patient should not be dismissed for the day, however, until an attempt has been made to pass a 20 or 22 F sound as these occasionally can be passed where smaller instruments cannot.

With experience one soon recognizes a certain sensation imparted by a filiform successfully passing through a stricture. Unless such a sensation is encountered, one must suspect trouble in the form of buckling or breaking of the filiform. The buckling may even progress to the formation of a figure-eight knot. Once the filiform has entered the stricture, it is a simple procedure to attach a Phillips bougie or catheter. The latter is preferable since its entrance to the bladder is indicated by the appearance of urine thus adding another assurance that the stricture has been successfully passed. In those instances in which a Phillips bougie or catheter is not stiff enough to dilate the stricture, a Le Fort sound is used instead.

The degree of dilatation which may be carried out at each treatment varies. Most gonorrhreal strictures are located in the bulbous and membranous urethra. In this area they dilate easily whereas those occurring in the scrotal and pendulous portions dilate with much greater difficulty. As a rule, it is wise to pass no instrument larger than 8 or 10 F in size on the first attempt. Subsequent visits usually are made in from five to seven days, at which time the dilatation is usually begun with an instrument of the same size or one size less than the largest size used on the previous visit. Dilatation is usually not carried out with instruments more than from two to four sizes larger than the instrument of maximum size used on the previous visit.

In many instances it is possible to substitute woven bougies for the filiforms and followers after the initial dilatation has been carried out. When size 18 or 20 F has been reached, steel sounds are preferable in most instances as they are less painful. Some patients, however, prefer bougies for all dilatations. The size of the largest sound passed is limited by the size of the meatus. If the meatus is small, one may either perform a meatotomy or use a Kollmann dilator.

Once the maximum size for a patient has been reached without causing hemorrhage and without the urethra grasping the sound too tightly, the interval between dilatations is gradually lengthened, first by weeks and then by months until an interval of six months is reached. There should be no greater interval than six months except in those rare instances when a cure is obtained by dilatation. It should be remembered that no hard and fast rule applies to the interval

between dilatations. This must be worked out for each individual case.

Indications for operative treatment of strictures are several. Those not responding to periodic dilatations, all strictures of the meatus, impassable strictures and those complicated by periurethral abscess require cutting. In general, strictures of the scrotal and pendulous urethra as well as traumatic strictures of the deep or membranous portions respond satisfactorily only to surgical division. In those instances in which patients cannot make regular office visits for dilatation of strictures, it may be necessary to perform a urethrotomy.

Internal urethrotomy is most successfully employed in strictures of the pendulous and scrotal urethra and should not be used where periurethral infection is present. Its execution precludes the passage of a filiform. Three types of urethrotome in common usage are the Maisonneuve, the Otis and the Riba. The last named is most desirable from the standpoint of hemorrhage since it coagulates as it cuts. The Otis and Riba urethrotomes are safer because they cut the stricture while the surgeon withdraws the instrument. They are first inserted to a distance of from 1 to 2 cm. beyond the stricture, the cutting edge is then turned up to 30 or 32 F and withdrawn through the stricture. The Maisonneuve urethrotome, on the other hand, cuts the stricture by forcing the knife through it toward the bladder, thus endangering the sphincter muscles. Furthermore, the size of its knife is not variable. The use of the Otis urethrotome is limited to the larger strictures. Internal urethrotomy should be carried out only along the roof of the urethral canal inasmuch as a deep cut there is less apt to produce abscesses since only the septum between the corpora cavernosa may be invaded. It should be possible after performing an internal urethrotomy to pass a 30 F sound. Failing this, the stricture should be cut again and even a third time if necessary. An indwelling catheter is then placed to control hemorrhage. This is not so essential when the Riba urethrotome is used. The penis should be inspected at least twice daily for evidence of periurethral inflammation, and if it is present, the catheter should be removed.

External urethrotomy is employed chiefly for strictures of the deep urethra, for impassable strictures and where periurethral infection is present. It is a considerably less formidable

procedure in those instances in which some instrument, such as a grooved staff, sound or bougie, can be passed since it not only outlines the course and position of the urethra but also brings it closer to the surface. Division of the stricture is made over this instrument, and dilatation is carried both into the bladder and retrograde with bougies or sounds. A large caliber self-retaining catheter is then placed through the entire urethra, and the incision is closed in layers. At no time should the urethrotomy opening be explored with a finger as this procedure causes too much trauma. Only a cystoscope or urethroscope should be used for this purpose.

Impassable strictures may be treated surgically by external urethrotomy, or by the retrograde route through a cystotomy approach. When an external urethrotomy is performed in such cases, the introduction of methylene blue or indigo carmine into the urethra is of inestimable aid as it usually can be milked through the stricture. After the dye is introduced, a sound is passed as far as permitted and an incision is made down to its tip. Then by careful dissection the course of the tinted urethra is pursued, and the strictured orifice is located by means of a filiform. Thereafter the procedure is no different from external urethrotomy in passable strictures.

A less tedious and exasperating procedure is retrograde dilatation of a stricture through a suprapubic incision. Many impassable strictures become passable when this approach is used, and dilatation can be carried out readily. Occasionally it is necessary to perform this surgical measure in combination with an internal or an external urethrotomy. In locating a stricture which is impassable by the retrograde route, sounds are passed as far as possible through the internal and external urethral orifices. External urethrotomy is then performed by using sounds as guides. A urethral catheter of large caliber is left in place as well as a suprapubic tube. It should be pointed out that no matter what type of surgery is performed on a stricture, sounds should be passed in from seven to ten days after the catheter is removed and then regularly at intervals of from five to seven days until the optimum size of the urethra is maintained. Thereafter the interval between dilatations may be gradually lengthened. Although surgical intervention cures many strictures, in some cases the regular passage of sounds will continue to be required while in others the operation will need to be repeated. The possi-

bility of recurrence must always be kept in mind. When extensive multiple strictures exist, both internal and external urethrotomy may be required.

Meatotomy is easily carried out under local anesthesia produced by novocain. Hemorrhage is troublesome, but not serious and can be controlled more easily with the electric than the cold knife. The meatotomy clamp and Monsel's solution are helpful aids. Occasionally it is necessary to place catgut sutures to control the bleeding. The incision is made on either side of the frenulum and carried sufficiently into the fossa navicularis to facilitate the easy passage of a 30 or 32 F sound. A vaseline wick is of aid in keeping the cut edges separated.

Traumatic strictures as a rule contract more rapidly, require surgical intervention more often and recur more readily than gonorrheal strictures. They usually accompany straddle injuries or fractures of the pelvis. Their adequate treatment includes proper care of the urethra at the time of injury. If it is not completely divided, an attempt should be made to place an indwelling catheter. After its removal the urethra should be regularly calibrated and treated for stricture in the prescribed manner, should one occur.

If an incompletely severed urethra cannot be catheterized, or if there is complete division of the urethra, immediate surgical treatment is indicated to prevent extravasation of urine. A suprapubic cystotomy is almost always employed in such cases. If the patient's general condition will permit, an immediate attempt to pass a catheter through the entire urethra should be made. This procedure may require an external urethrotomy. Unfortunately, medical care frequently is not obtained soon enough, or the shock attending the injury is so great in many cases that only cystotomy is indicated at the time. Extravasated urine must, of course, be liberated as soon as discovered by wide multiple incisions, no matter where found.

Internal urethrotomy is best suited for treatment of established traumatic strictures of the anterior urethra. External urethrotomy, on the other hand, is more suitable for those located in the membranous portion.

As is true of surgery in general, the proper treatment of strictures implies adequate preoperative preparation and postoperative care in addition to the best surgical technic. Renal function should be kept at an optimum by adequate fluid

intake and electrolyte balance as well as sufficient bowel elimination. Infection must be kept under control by the best antiseptic and aseptic technic plus the administration of the sulfonamide drugs. Gentleness should prevail in all instrumentation and manipulation in order to minimize hemorrhage and eliminate trauma. Pulmonary complications should be prevented by careful choice of anesthetic. Prevention can best be accomplished by using local infiltration anesthesia for meatotomy, local topical anesthesia for internal urethrotomy and block anesthesia for external urethrotomy. Follow-up care must be regular and persistent. Only by following such a regime can one hope to reduce the unnecessarily high morbidity and mortality which accompany the formation and treatment of urethral strictures.

307 S. Orange Ave.



## TONSILLECTOMY VERSUS TONSILLECTOMY

REPORT OF TWO HUNDRED AND SIXTEEN CASES

H. H. WHITNEY, M.D.  
TAMPA

It is my desire to mention briefly certain aspects of the surgery of the lowly tonsil. Specifically, I wish to set forth some conclusions that have been drawn from the results of 216 tonsillectomies done over a period of twenty-six months.

In most of these operations an automatic mechanical device was used to remove the tonsil. This machine has two blades and is constructed after the fashion of the better Sluder instruments. One blade is dull and hemostatic, and is applied first, for the purpose of peeling the tonsil from its bed and controlling hemorrhage; the other one, very sharp, slips along beside it, in another operation of the hand, and cuts the compressed tissues free. Both blades are then released, and the tissues retract leaving the tonsillar fossa clean and usually free from bleeding, or at most, with a few bleeding points.

It is a simple and satisfactory instrument. No dissection is required, and once the operator has become adept, a tonsil can be removed in ten or twenty seconds. The chief objection to the use of the instrument is that considerable strength of the hands, as well as some training in manipulation, is required to perfect the technic. The

instrument is usually used either very well or very badly.

The other method of removing tonsils employed in this series of cases was that of careful dissection and simple snare. This method has been used in considerably less than one fourth of the operations and seems indicated in tonsillectomies in adults under local anesthesia, or in the removal of small scarred tonsils when dissection is usually imperative. While the automatic mechanical instrument has been used many times in connection with local anesthesia in this series, in general it is not the instrument of choice. I have used it in children down to the age of 7 in cases in which general anesthesia was contraindicated because of severe cardiac lesions.

A perfect tonsillectomy consists of removal of the tonsil, the whole tonsil, and nothing but the tonsil. The appearance of such a tonsil, when removed, is clean with practically no gross evidence of muscular attachments. The pathologists assert that the tonsils have no true capsule, yet on removal with the mechanical device they are practically always enclosed in a rather neat fibrous covering. When properly removed, the tonsil appears slightly trabeculated because of the pull of the fibrous connective tissues between the various lobules of the tonsil. This covering is actually a part of the sheath of the palatoglossal and the palatopharyngeal muscles, which comprise the tonsillar cradle. It is worthy of note that the remaining tonsillar fossa has a similar covering to that of the capsule, so that it seems evident that the muscular sheath is split, part remaining on the tonsil and part firmly adhering to the muscle. Such results are not usually obtainable by the dissection and snare method of tonsillectomy.

Fowler,<sup>1</sup> in his comprehensive book on tonsil surgery, stated that he had demonstrated fibers of the palatopharyngeal muscle which run into the tonsil and attach themselves to the capsule at the junction of the upper and lower lobules of the tonsil. He called this the tonsillopharyngeal muscle, and insisted that if it is not carefully dissected free from the tonsil, the tonsillectomy is complicated by removal of excessive muscular tissue and often by hemorrhage. Whether or not such a muscle exists, it certainly presents no problem in tonsillectomies done with an automatic instrument because when properly handled, the instrument is also an automatic dissector.

An objection to the use of the automatic me-

chanical devices lies in the tendency for lymphoid tissue to grow back into the fossa some weeks or months subsequent to operation. The tonsil is the chief component of Waldeyer's ring, which is a ring in the nasopharynx consisting of the adenoid masses, pharyngeal and faucial tonsils, infratonsillar nodules and the lingual tonsils. The infratonsillar nodules consist of mucous glands and membranous tissues similar in structure to the lingual tonsil, of which they seem to be a part. They are located just below the lower pole of the tonsil at the base of the tongue. It is from this structure that the tonsillar fossa begins to refill in many cases following tonsillectomy with an automatic mechanical device.

Indeed, if the machine is not properly manipulated, or if the infratonsillar nodules are not included in the tonsillectomy, there will always be greater or less regeneration from these nodules up along the lateral wall of the fossa. This is also true, however, of tonsillectomies inadequately done by any method, and checks on recurrences in large clinics show percentages of regeneration in tonsillectomies done by all methods to be exceedingly high, in some instances as high as 73 per cent.

It has been the practice in this series of cases to elevate the mucous membrane at the lower pole of the tonsil with a pair of Allis forceps and to clip a slight nick at the base of the tongue distal to all evident lymphoid tissue. Then starting the mechanical instrument at this point the infratonsillar nodules are included as part of the tonsillectomy. This procedure is often done by most operators as a part of the dissection when the simple snare is used, and probably its inclusion accounts for the lesser tendency to recurrence of lymphoid tissue with the dissection and snare method.

Hemorrhage during the operation was not a problem in the cases of this series. It occurs by any method, but, on the whole, less with the automatic mechanical device, and in most of these cases it was slight. In some instances it was necessary to ligate a small vessel. Ligation is usually done with a circumcision suture on a sharply bent needle. For the most part I use nothing at all, or, at most, a compression sponge saturated with compound tincture of benzoin.

In 6 cases delayed hemorrhages occurred five or six days postoperatively. These were readily controlled, and the method of tonsillectomy seemed to have no bearing on the complication.

Elevation of temperature for a week was reported in 1 case. Otherwise, there was no morbidity, and there was no mortality rate.

In the Hillsborough County Hospital, I have been contrasting these two methods of tonsillectomy and in some cases have used the snare and dissection method on one tonsil and the mechanical device on the other tonsil in the same patient, thus having an excellent opportunity to compare the two methods under identical conditions.

#### CONCLUSIONS

1. Tonsillectomy when properly done with an automatic mechanical device is faster and cleaner than when done by the snare and dissection method.
2. There is a greater tendency to the regeneration of lymphoid tissue when tonsils are removed by an automatic device.
3. To insure no regeneration whatever of lymphoid tissue, slight dissection of the infratonsillar nodules is sometimes necessary.
4. There seems to be somewhat less bleeding at the time of operation when an automatic instrument is used.
5. No differences in other complications have been noted in the two methods contrasted.
6. Mechanical devices offer no especial advantages in tonsillectomy except possibly the benefit of increased speed of operation.

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## SARCOMA OF THE PATELLA

## REPORT OF A CASE

FRED H. BOWEN, M. D.  
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Approximately 27 sarcomas and 17 giant cell tumors of the patella have been reported. There is a possibility that the sarcoma considered in this paper may have originated in a giant cell tumor; hence I feel justified in recording this case.

## REPORT OF A CASE

The patient, a 71 year old woman, was admitted to the West Baltimore General Hospital on April 30, 1940, complaining of severe pain and swelling in the left knee. About two and one-half years before admission she had struck her knee on the door of an automobile, and for one month after this trauma she limped and was unable to go up or down stairs. The knee gradually improved, and the patient experienced no further difficulty until approximately two years before admission. At that time she had gone for a three hour automobile ride, and on returning she could not move her leg because it was "sore." She was unable to walk and had to be carried into the house. Thereafter she was not able to walk over 25 yards without sitting down to rest and spent most of her time in a chair. Hot applications and various liniments were applied to the knee, but the patient experienced no relief. Six months before she entered the hospital, the knee began to swell and to hurt badly even when it was at rest. A physician, whom she consulted two and one-half months before admission, observed a fusiform swelling of the knee joint with displacement of the patella toward the lateral side. He also noted several areas of tenderness about the knee. Heat, tight bandaging and small doses of cinchophen were prescribed, and the patient experienced slight symptomatic relief. One and one-half months before she was admitted, the region of the prepatellar bursa was aspirated, and a bloody fluid was obtained. The pain became progressively worse, and she came to the hospital for diagnosis and treatment.

On physical examination, the patient was noted to be a moderately obese woman, who was complaining of pain in the left knee. The rectal temperature was 101 F., the pulse rate 110 and the respiratory rate 26. Occasional dry rales were heard at the base of the left lung. The left knee was tremendously swollen, and bluish dilated veins were seen beneath the tense waxen skin. The portion exhibiting the most swelling was anterior to the patella. The swelling had the consistency of adipose tissue over which the skin had been tensed, and this region of the knee was very tender. The reaction to the Eagle test was negative, and urinalysis and routine blood studies gave normal results. The region of the prepatella bursa was aspirated, and a sterile bloody fluid was obtained. A roentgenogram of the left knee revealed a fragmentation and irregular sclerosis of the patella (fig. 1).

Four days after the patient was admitted to the hospital, a specimen of the patellar tumor for biopsy was taken under spinal anesthesia. A longitudinal incision was made over the lateral border of the patella, and a soft mushy white tissue was encountered immediately beneath the skin. The growth was emanating from the lateral side of the bone, which was soft and crumbly. A portion of the patella was easily broken off with a clamp and removed together with some of the tumor tissue. The microscopic description of this tumor was the same as that noted in the report of the autopsy.

A few days later, a roentgenogram of the chest revealed clouding of the lower half of the left lung and of the interlobar part of the right lung. Following biopsy,

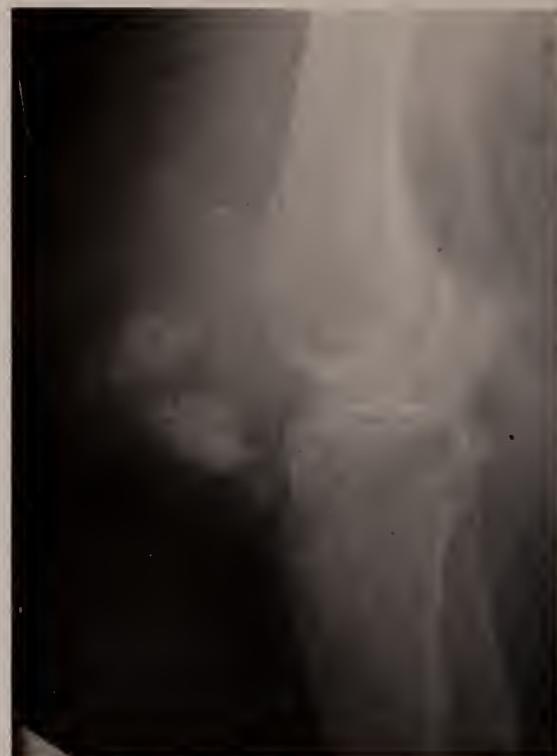


Fig. 1. Roentgenogram of the left knee showing fragmentation and irregular sclerosis of the patella.



Fig. 2. Anterior view of the knee taken immediately after death.



Fig. 3. Lateral view of the knee taken immediately after death.

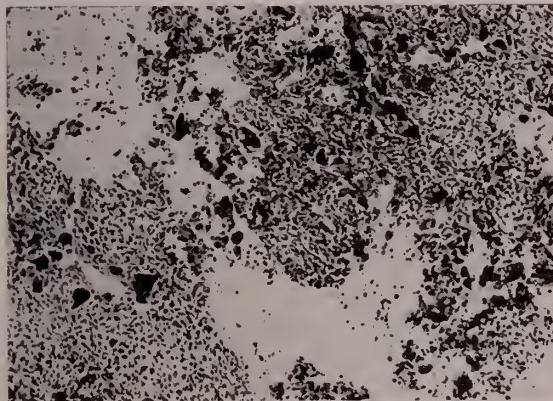


Fig. 4. Sarcoma of the patella. Note the spindle-shaped hyperchromatic cells, vascular spaces and multinucleate giant cells.

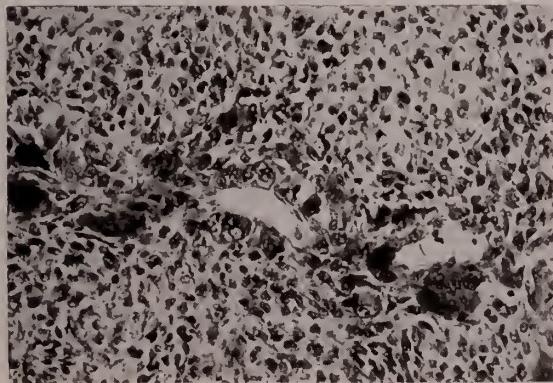


Fig. 5. Higher magnification of a field from the primary tumor. Note the spindle osteogenic cells and large nuclei. Evidence of mitosis is abundant. The stroma is composed chiefly of these cells and the multinucleate giant types. There is some evidence of bone formation.

the temperature was elevated to 101 F. nearly every day until the patient's death. The sutures were removed on the ninth postoperative day, and a superficial infection was noted. Frequent dressings were done, and the tumor was seen to grow out of the operative site, forming a fleshy, bleeding mass. The prepatellar region was enormously enlarged by the tumor, and the weight of the tumor kept the leg continuously in a position of external rotation. Roentgen therapy to the knee and chest was advised and refused. The growth of the tumor was rapid, and the patient began to cough frequently and to breathe rapidly. A roentgenogram of the chest taken five weeks after the biopsy showed an oval shadow at the apex of the left lung, and examination revealed that the liver was enlarged. The condition of the patient became progressively worse, and she expired seven weeks after admission. Figure 2 shows an anterior view and figure 3 a lateral view of the knee taken immediately after death.

#### PATHOLOGIC REPORT

The body was that of a white woman, 71 years of age, with a large swollen ulcerated lesion on the left knee. In the apex and the posterior hilar region of the left lung were found two small nodules about 3.5 cm. in diameter. In the apex of the right lung there were two small nodules which were 1.5 cm. in diameter. Multiple small diverticula of the sigmoid colon were present. Six gallstones were found in the gallbladder. A necrotic ulcerating mass was present over the left knee. This process extended down to and involved the patella.

On microscopic examination the tumor was seen to be composed of many hyperchromatic osteogenic spindle cells with large nuclei and multinucleate giant cells containing hyperchromatic nuclei. Evidence of mitosis was abundant. The stroma was composed chiefly of these spindle cells and multinuclear giant cells. There was some evidence of bone formation. Large vascular spaces were present in the tumor (figs. 4 and 5).

The sections from the lung showed many dilated alveoli, some of which contained fluid and exudate. A section from a nodule in the lung showed it to be composed of many spindle cells, among which were situated occasional giant cells (fig. 6). Examination of the kidneys revealed cloudy swelling of the tubules.

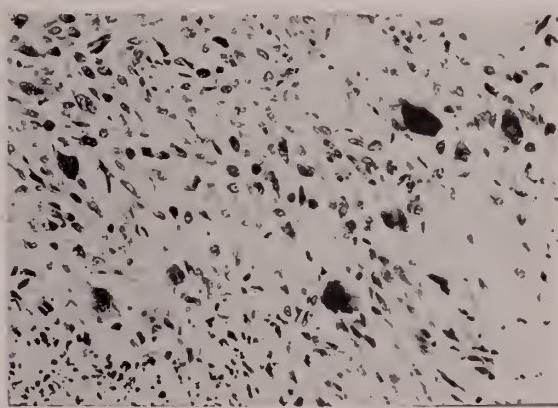


Fig. 6. Higher magnification of a field from the metastatic nodule in the lung. Note the similarity of the growth and the presence of the giant cells.

#### COMMENT

The patella is remarkably free of bone tumors in spite of the fact that it is probably more frequently traumatized than any other bone in the body. Christensen,<sup>1</sup> in explaining the relative infrequency in this location stated:

It seems reasonable to assume that the immunity to bone tumors which the patella enjoys is probably due to the absence of loss of growth restraint, incident to active diaphyseal growth and pressure epiphyses. The fact that the patella develops from an endochondral center, that it has a relatively short period of growth, and that it is a sesamoid bone, may be of importance.

In 1924, Kienbock<sup>2</sup> divided tumors of the patella into exostoses, chondromas and sarcomas. He collected 16 cases of sarcoma of the patella and added 1 of his own. Of the 16 collected cases, one was described as that of a spindle cell sarcoma showing giant cells (Creite); another was described as that of a round cell sarcoma showing some spindle cells and giant cells (Wanach). There is nothing to suggest that either of these tumors was a giant cell tumor which underwent sarcomatous changes. In 1925, Cole<sup>3</sup> collected 2 proved and 2 doubtful cases of sarcoma of the patella not reviewed by Kienbock<sup>2</sup> and reported 1 case. He also reviewed 1 case of exostosis of the patella, 2 cases of cartilaginous exostosis, 1 case of osteochondroma, 1 case of chondroma and 1 case of giant cell tumor. Also in 1925, Christensen<sup>1</sup> mentioned 2 cases of sarcoma of the patella. In 1931, Pillet<sup>4</sup> reported a fatal case of chondrosarcoma of the patella. Pizzagalli<sup>5</sup> recorded a case of sarcoma of the patella in 1931.

In 1940, Richards, Giberson and King,<sup>6</sup> collected 16 cases of giant cell tumor of the patella and added another. Linde<sup>7</sup> made the statement: "No case of giant cell tumor of the patella has shown a malignant or metastatic behaviorism." Coley,<sup>8</sup> however, stated that although giant cell sarcoma is usually benign, it should still be classed as a sarcoma because in certain cases it has all the features of malignant tumor causing death by metastases. The case herein reported is believed to be the only case on record of a sarcoma of the patella which may have originated in a giant cell tumor.

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#### RETINAL HEMORRHAGE IN A CASE OF RATTLESNAKE BITE

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PENSACOLA

The occurrence of retinal hemorrhage in the case of a patient bitten by the Florida diamond-back rattlesnake (*Crotalus adamanteus*) has been the stimulus for much study on my part relating to the ocular effects of snake bite. I knew little or nothing about the subject at the time I first saw the patient in this most interesting case. In reviewing the literature I found no report of a case of rattlesnake bite with this complication. Peculiarly enough most of the reports of cases of snake bite by poisonous vipers have come from foreign lands.

Tisdell<sup>1</sup> in the Medical Journal of Australia reported the ophthalmologic findings in a case in which the patient was bitten by a tiger snake. He stated there was bilateral ptosis, the left lid being drooped rather more than the right. The pupils were widely dilated and completely inactive. Doughty<sup>2</sup> in California and Western Medicine reported 2 fatal cases of rattlesnake bite, the only reference to the eyes being that they were contracted. Needless to say, since there were only these few reports of cases of rattlesnake bite which so much as mentioned ocular symptoms and since in none of the cases reported was the patient bitten by the *C. adamanteus*, I turned to other sources in search of knowledge on this subject.

The physiologic action of rattlesnake venom has been classified as (1) neurotoxic, (2) agglutinant, (3) cytolytic, (4) thrombopoietic and (5) antibactericidal. The hemorrhagic principle of *crotalus* venom possesses the following properties: it is nondialyzable, destroyed by heating to from 75 to 80 C., precipitated, but not destroyed, by alcohol, easily destroyed by weak acids, but not weak bases, destroyed in the alimentary canal by gastric or pancreatic enzymes, and stable in 50 per cent glycerin or in the dried state. The hemorrhagic activity is directly proportional to the percentage of globulin-like bodies in the venom. The venom of *C. adamanteus* is the richest of all the crotalidic venoms in hemorrhagin content. For this information I am indebted to the medical division of Sharpe & Dohme, Inc.

The histologic changes caused by the hemor-

rhagins of snake venoms may be briefly summarized as follows: The endothelial cells of the walls of the blood vessels are attacked, and cytolysis occurs. Extravasation takes place not by diapedesis, but through actual rents in the walls of the vessels. This escape of corpuscles by dissolution of the walls of the vessels is limited to capillaries and small veins. Giant cells are formed in some vessels by fusion of intravascular leukocytes and they block the small vessels when they are formed. To these hemorrhagins must be attributed hemorrhage which occurs not only in more or less extensive extravasation of blood around the site of the bite, but also in other parts of the body, especially the exposed mucous membranes. Vomiting of blood is a common sequel to snake bite, as is hematuria. Hemorrhage from the bowel is not uncommon, and bloody tears, from extravasation in the lacrimal gland or the conjunctiva, have often been reported. Internal hemorrhages are apparently much less common, but perhaps only because they are not readily observed. I have heard of temporary loss of vision following the bite of the American pit vipers, but so far as I am aware, this symptom has always been attributed to the neuroparalytic action of the venom. It seems not unlikely that some of the loss of vision in cases of this type may be due to unrecognized retinal hemorrhage.

The specific antivenin neutralizes not only the neurotoxic component of the venom, but also its hemorrhagin. Of course neutralization is not always complete because of inadequate dosage, the occurrence of lesions before the antivenom is administered, or unusual sensitiveness of the victim or of some particular organ.

I know of 2 cases occurring in Florida that were similar to mine, neither of which was reported in the literature. In one case the hemorrhage was postretinal, causing detachment of the retina. The second case was that of the wife of the owner of the rattlesnake cannery at Rattlesnake, Fla. While a large snake was being transferred into a pen, the venom sprayed out entering both of her eyes. The eyes smarted immediately and became very red. They were irrigated, and in about three hours the redness of the conjunctiva subsided with no ill effects.

I believe the incidence of snake bite by the Florida diamondback rattlesnake is much more common than reported by Githens<sup>3</sup> in "Snake Bite in the United States." In this article he

stated that over an eight year period from 1927 to 1934 there were only 70 persons bitten by this snake; poisonous snakes bit 2,376 persons in the whole United States during this period. His information was derived from two sources: the first and by far the more important was the report forms which accompany each package of anti-venom and which many physicians who have treated snake bite take time to fill out; the second was newspaper items describing bites. The Florida diamondback is found mostly in wild regions, and presumably this fact and the fact that this rattler is the largest and most dangerous serpent in the state indicate that many of those bitten die without seeing a physician. Many home remedies are used, such as a poultice with a freshly killed chicken split and applied. Also, the physician in the small community is busy, and it is doubtful if he reports many cases he treats. Few here will ever have occasion to see or treat a case of snake bite for two reasons. The first is that ophthalmologists are located in thickly settled communities, and the second and more important is that the family physician is usually called when a person is bitten.

For those who are fishermen and hunters I wish to outline the local and general effects of snake bite as well as the treatment. The venoms are complex mixtures containing several poisonous substances, some of which act locally on the tissues near the site of the bite and others, after absorption, on the vital organs of the body. In bites in large animals, the most commonly observed local effects are, first, an injurious action on the small blood vessels (hemorrhagin effect), permitting the blood plasma to escape through their walls, thus giving rise to a local edematous swelling, and, secondly, a destruction of the red blood cells (hemolysin effect), which causes a dark purple discoloration of the skin.

The most important general effects include a paralytic action on the voluntary muscles, resulting in great weakness; a similar effect on the muscles of respiration and the respiratory center, causing shortness of breath; and a weakening of the heart action and depression of the vasomotor center, accentuating these symptoms. There is also poisoning of the higher nerve centers, indicated by faintness or loss of vision and often leading to complete collapse. After a bite by a large snake, death may occur from shock without consciousness being regained.

The greater part of the venom is commonly held for several hours in the local edematous area and gradually absorbed through the lymphatics. The most approved method of treating snake bite is based on this fact. Treatment is of two kinds: (1) local, designed to delay the passage of venom from the site of the bite to the vital organs and to remove as much of it as possible before it is absorbed; and (2) general, designed to neutralize the absorbed venom and to minimize its effects.

Local treatment is facilitated by the fact that bites by poisonous snakes are almost always inflicted on the extremities. Less than 1 in 100 is on the trunk or head. The first thing to do is to apply a tourniquet around the limb above the site of the bite, tightening it until the pulse can barely be felt. It is not wise to cut off the circulation from the limb entirely for a prolonged period of time as gangrene in the region of the bite might result. If the limb becomes cold or numb, the tourniquet should be removed for a minute or so until the circulation is reestablished and then applied more loosely.

Next, short incisions are made over the marks made by the fangs. Multiple cuts are also made through the skin around the edge of the swelling. The bloodstained fluid will ooze from these cuts carrying with it some of the unabsorbed venom, and its escape should be aided by applying suction either with a mechanical device or with the mouth. The oral method is comparatively safe if there are no sores around or in the mouth or throat, as the venom is not readily taken up from an intact mucous membrane and small amounts swallowed are destroyed by the digestive juices. As a precaution, the wound or the mouth may be rinsed with a dilute solution of potassium permanganate, which destroys the venom on contact. As the swelling spreads up the limb, new incisions are made near its edge and suction applied to these. The suction is used for about fifteen minutes in order to remove as much of the fluid as possible, and the part is then covered with a cloth soaked in a strong solution of salt or epsom salt, or in an antiseptic which will not precipitate proteins. After forty-five minutes suction is again applied for fifteen minutes, and the part is again covered. This routine is continued for from five to fifteen hours according to the seriousness of the symptoms. In case the flow of the serum is not free, sterile salt solution should

be injected near the site of the bite to wash out the venom.

Having initiated the local treatment, procedures for combating the general effects of the venom on the body are undertaken. The most important of these is the administration of antivenin. This is injected intramuscularly or subcutaneously above the tourniquet. The injection may be given in two ways. It may be introduced into a large muscle high up on the bitten limb, such as the deltoid, quadriceps or gluteus, or it may be given under the skin of the abdomen or between the shoulders. If an ample supply of antivenin is at hand, part may be given to advantage near the bite to help combat the local effects of the venom. The antivenin should be given as soon as possible after the bite has been received.

When death results it is usually not until several hours have elapsed. If the person is already completely paralyzed or in deep coma when the serum is given, very large doses, at least 50 cc., must be given at once, preferably intravenously. It is well to remember that a child requires as much antivenin as an adult for the dose is in proportion to the amount of venom injected when the person is bitten and has no relation to the body weight. Statistics indicate that the use of antivenin reduces the mortality to about one fourth of that in cases treated without it, even when cases in which the patient was evidently beyond help are included in the figures.

After administration of the antivenin, there will usually be a prompt improvement in the general condition, but if the dose is inadequate, the condition will again grow worse as more venom is absorbed. The patient must therefore be watched carefully for a day or two. The need for further injections is shown by continued shortness of breath, general weakness, failing pulse, vomiting, especially of blood-stained material, and faintness.

Of general measures aside from the use of antivenin, sedatives, such as morphine or aspirin, may be given to relieve severe pain. Alcohol is injurious as it hastens the absorption of the venom. For collapse, strychnine, aromatic ammonia and other general stimulants are of value. In all severely poisoned persons, great relief is experienced from infusion of large amounts of physiologic saline solution, or still better, transfusion of blood, the effect of which may be life-saving in borderline cases.

## REPORT OF CASE

J. H., a farmer aged 24, was referred by Dr. E. L. Huggins. His complaint was that about three weeks previously he had been bitten by a rattlesnake and since that time had not been able to see well out of his left eye.

According to the history, the patient consulted Dr. Huggins on Oct. 9, 1937, at about 7:30 p.m. His temperature was normal, and the pulse rate was 150. He related that he had been bitten by a large rattlesnake in a bean field, and after running a mile to where his mule was tied, he rode home and then came to DeFuniak by car. He was greatly excited and had a tourniquet on his leg so that the circulation was cut off. The ankle and leg were very edematous. The tourniquet was released and moved up the leg about 6 inches every fifteen minutes. Numerous incisions were made in the epidermis, and suction was applied. He remained in the office in bed for twenty-four hours. During this time 60 cc. of antivenom was given, 20 cc. when he first came in. At the end of six hours he was much calmer and feeling much better. At this time 20 cc. was given, and another 20 cc. was administered at the end of eight hours. The giving of the antivenom was governed according to the patient's condition.

On October 30 when the patient consulted me, ophthalmologic examination revealed that vision in the right eye was 20/20 and in the left eye 20/200. With lenses I was not able to improve the vision in the left eye. Examination of the fundus of this eye revealed a large round-shaped hemorrhage about one and a half times the diameter of a disk in size. It involved the portion of the retina on the temporal side of the macula area and bordered upon this area. The fundus of the right eye was normal. The peripheral visual fields were within normal limits. Some difficulty was experienced in getting the patient to watch the target. External examination of both eyes was essentially negative; no difference in the size of the pupils was noted. The pupils were dilated with 8 drops of 2 per cent homatropine containing 1/2 per cent cocaine, and refraction was again attempted. With a plus .75 sphere, plus .50 cylinder and axis 90, the vision in the right eye was 20/15. The patient was able to see faintly the 20/200 line with or without lens with the left eye. Due to the history of no trouble with his vision before the patient was bitten by the snake, I concluded this hemorrhage was probably the result of the destructive action of the hemorrhagin upon the vessel or vessels of the retina.

I have written the patient asking him to come to my office for a subsequent examination, but I have not been successful in getting him to do so. Consequently, I do not know whether part of this hemorrhage has been absorbed, or what vision he has at present. I do know he is farming, and he stated he can see "pretty good."

## SUMMARY

Retinal hemorrhage is rare in patients bitten by poisonous snakes, but much knowledge could be gained if all such patients were examined with an ophthalmoscope. The frequency of this complication could be more accurately determined if those patients who experience a loss of vision were examined before death ensues, for at present this loss is attributed to poisoning of the higher nerve centers.

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ADMINISTRATION OF A SMALL COUNTY  
HEALTH UNIT

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FERNANDINA

It would be well for each director of a county health unit in Florida to familiarize himself with the laws, rules and regulations under which his health department is established and under which it functions. With the provision that they may not conflict with any legislative act, the rules and regulations of the State Board of Health have the full force and authority of law, and penalties may be provided and enforced for their violation. The powers of the State Board of Health can only be abrogated through an amendment to the Constitution.

As health officers we are fortunate that we have this three man board that is well informed and responsive to the public health needs of the state and that can act quickly and efficiently in the presence of an emergency. The rules and regulations of this board and the considerable volume of special acts of the legislature pertaining mostly to sanitation and to health units constitute the legal background for our public health activities.

The Governor of Florida in the exercise of his authority appoints an executive officer known as the State Health Officer. This officer is clothed with the power and responsibility of taking all necessary steps for the protection of the health of the people. Whenever reference is made to the authority of a county health officer or of a director of a bureau or division of the State Board of Health it is understood that such authority is exercised by virtue of the powers which have been delegated by the State Health Officer and the State Board of Health. The office of Director of the Bureau of Local Health Service has been created for the purpose of carrying out the functions of the State Health Officer in so far as they pertain to county health units.

The Director of the Bureau of Local Health Service supervises the work of county health units, and such supervision covers the following points:

1. Promulgation of standards governing programs and general conduct of the work of the county health unit.
2. Specifications for qualifications of the personnel employed in county health units.

3. Planning and setting up budgets for county health units.

4. Acting as liaison officer between county unit directors and all directors of bureaus and divisions of the State Board of Health.

All other bureau and division directors and technical employees of the State Board of Health serve as consultants on technical subjects to county health workers on the request of the director of the county health unit. All requests or communications from a director of a local health unit should go through the Bureau of Local Health Service. In the same manner, all requests or communications to or from the personnel of a local health unit should go through the director of the unit.

This chain of authority is according to the laws, rules and regulations under which we function as directors of local health units. Compliance with these rules will eliminate much confusion that might arise from multiple supervision and divided authority. In this time of stress and strain when every effort should be put forth to conserve and to protect the people's health as a measure of defense, it is most fortunate that politics in public health has been adjourned and, we may hope, definitely abolished.

After many years of experiment by the trial and error method, it has been determined that public health administration in a democracy can best be carried out through local health units. In Florida the county has been chosen as the administrative area and an act of the legislature provides for the establishment of county health units. The act sets out:

1. The manner in which such units may be established.

2. That taxes may be levied by the county for the maintenance of the unit. (By a construction of the law, counties now allocate monies from the race track and other funds.)

3. The manner of selecting the personnel for county health units. (Retaining in the hands of Boards of County Commissioners the employment of such personnel.)

4. That the directors of such personnel shall be physicians who are skilled in the practice of preventive medicine and are licensed and registered in Florida.

5. That other personnel shall be nominated by the director of the unit.

6. That such personnel shall be approved by the State Health Officer.

7. That the minimum personnel shall consist of a director, a nurse, a sanitary officer and a clerk.

The preceding sections of this paper are all an attempt to show the legal background and to clarify the authority under which our duties are performed. It is to be observed that:

1. The physical setup of a county health unit is the province of the local Board of County Commissioners to a large extent. Also, the health unit must obtain the approval of the Board of County Commissioners for employment of personnel and for budget allocations.

2. All supervision and all authority of the unit in performing its functions derive from the State Health Officer.

3. Since the director must be a physician licensed to practice medicine in Florida, he is at least under the ethical control of the Florida Medical Association. He is therefore expected to work harmoniously with the organized medical groups of his county and state.

A health officer should be trained to do the highly specialized work that is necessary for the efficient conduct of a county health unit. He should be able to adapt himself to his environment. He should acquaint himself with local customs and reactions. He should be contented in his new home.

On assuming the administration of a health unit the director should as rapidly and as thoroughly as possible know his community. He should study the geography, the roads, the towns, the rural communities and the population both as a whole and gradually as individuals.

All groups that may be of help should be inventoried and carefully appraised. County officers, city officers, school officers, medical and dental societies, civic groups of all types and luncheon clubs should be carefully cultivated. There will certainly come a time when the local Red Cross or American Legion or County Defense Council can and will come to your aid in an emergency. Use them all. They like it. Attend their meetings whenever possible and you will most likely be given a chance to discuss your work. The Rotary Club, for instance, will call on you to pinch hit when their scheduled speaker has

fallen down on his assignment. A friendly police force is most helpful.

The countywide public health committee can be of great assistance in securing the appropriation of county funds. All of the groups mentioned and many others in Nassau County are active and fortunately are public health conscious.

The next step is to find the health problems. Study the vital statistics, compare the death rates with those of other counties. Discuss with physicians, nurses, teachers and others in the county what they consider their worst problems. From a careful study of local conditions you will determine your problems and from your acquired knowledge of them you will be able to determine your programs.

In Nassau county I have found that my chief problems are: (1) venereal diseases, (2) malnutrition, (3) poor sanitation, (4) high infant death rate, (5) lack of prenatal care, (6) tuberculosis and (7) physical and dental defects in children. These range in importance about as listed. There are other problems, of course, such as: (8) cancer, (9) hookworm, (10) communicable disease, (11) automobile deaths, etc.

My programs are built around my most serious problems. They include infant, preschool and school programs, maternal programs, venereal disease control, sanitation and a tuberculosis and other communicable diseases program.

There have been established in Nassau county four health centers. These are in the larger towns and are conveniently distributed about the county to be within the reach of as many people as possible. Where it is necessary, as it is in most rural counties, for a director to do most of his clinical work, it is a mistake to set up too many centers. There are only five and a half working days in a week, and, after all, a director necessarily needs some time to do his directing.

In every small hamlet you will find a few ambitious souls who crave the setting up of health centers in their midst and often you will find misapprehension as to the meaning of public health. Many think a center is a place where free treatment and much consolation are offered to all of the old arthritics, hypochondriacs and general misfits that can be rounded up.

In each of the four centers in my county a well child clinic is held once a month, and once a month a maternal clinic. In each center a venereal disease clinic is held once a week. As a matter

of fact, it is a difficult matter to limit well child clinics or maternal clinics to once a month. The patients who should attend these clinics drift into all clinics, and their needs are so apparent that I have not found the firmness or hardness of heart to make them wait for their regular schedule. Most of my clinics really take on the character of general clinics.

Much time, effort and money have been spent in efficiently equipping our health centers and in making them more comfortable and attractive. Our local public health committees have developed a great pride in their own local centers and have been most helpful in bringing them to a higher standard of equipment and appearance.

Cigar boxes and discarded cartons for files, and nondescript dry goods boxes for tables and chairs do not properly advertise the serious importance and dignity of preventive medicine. Abandoned barns and leaky shacks in unhappy surroundings have been used for health centers, but they do not inspire the health workers nor the public at large.

An adequate budget is constantly in the prayers of every director and is a goal toward which he is constantly striving. The men who hold the purse strings have to be shown. As we well know, they are human and lean well toward the Scotch side of the family when it comes to wanting to get adequate returns for money spent. This observation applies equally well to county commissioners and to the lads in Jacksonville.

Nassau county operated last year on a budget of about 80 cents per capita. This year it is spending approximately \$1.10 per person. We are working hard and fervently praying that this amount can be raised to about \$1.40 per capita for the year beginning next July. Even with that figure we will only be within yelling distance of our next door neighbor to the north, Glynn County, Georgia.

Another thing devoutly wished for by the administrator of a county health department is an adequate, well trained and enthusiastic personnel. The number depends upon the budget. Enthusiasm depends largely upon the type of director, and training is largely in the hands of the fates.

Nassau County a year ago had a director, a sanitary officer, a clerk and one nurse. This nurse tried to serve 12,000 people and an area that can be described by saying that from Fernandina, our headquarters, to the southwest border

of the county is a distance of 55 miles. Later we had two nurses, and now we have three. Of course, I should like to plan for four in the future.

#### CONCLUSION

To sum up the requirements for a successful administration:

Get adequate training.

Know the laws, rules and regulations by which you and your work are governed.

Pick your county carefully so that you may be reasonably contented.

Know your county and its people intimately.

Know your problems and strive to handle them adequately.

Plan adequate programs and follow them through.

Set up well equipped, convenient and attractive health centers, and not too many.

Set up your headquarters in the best building you can get. Adequately furnish and equip it. Make it a proper advertisement of your ability, your energy and your personality. Let it proclaim the importance and dignity of preventive medicine.

Get the best possible personnel, and as adequate in number as your budget permits.

Work always toward a better budget in order that you may do more and better work.

Work in close harmony with your State Health Officer and his directors. They are the best that Florida has ever had.

Act toward your local physicians as you would have them act toward you if your positions were reversed. You and they are all striving toward the same great end, a sound mind in a sound body for all.

Whenever possible, employ physicians to do your clinical work.

Keep in constant, friendly, helpful contact with your various county groups.

#### FIND PENICILLIN EFFECTIVE WHERE SULFONAMIDES FAILED

Effective use of penicillin in 3 patients with gonorrhea, in whom the infection was completely resistant to what might be considered adequate treatment with sulfonamide preparations, is reported by Wallace E. Herrell, M. D.; Edward N. Cook, M. D., and Luther Thompson, Ph.D., Rochester, Minn., in *The Journal of the American Medical Association* for May 29.

Penicillin is a recently discovered substance, obtained from a mold, which has been found to have remarkable powers of combating certain types of infections.

The three men say that their experimental evidence "immediately suggests that penicillin should prove effective in the treatment of clinical infections due to these sulfonamide resistant bacteria. . . .

"Because of the limited amounts of penicillin available, we feel that penicillin therapy should be reserved and studied further in those cases in which the infection is resistant to the accepted forms of treatment now being used. . . ."

They found that the several strains of the organism "are inhibited completely in fairly high dilutions of an active form of penicillin. Bacterial cultures reveal that the number of organisms is decreased greatly at the end of one or two hours' contact with penicillin. Between the second and third or third and fourth hours in contact with penicillin no viable organisms were found. . . .

"The complete absence of toxicity following the intravenous administration of pyrogen free penicillin, the lack of any discomfort to the patient and the rather rapid disappearance of the clinical symptoms have been observed in three cases of sulfonamide resistant gonorrhreal infections. In all the cases reported, in addition to the clinical response noted, negative bacterial cultures were obtained sometime between seventeen and forty-eight hours after the institution of penicillin therapy."

The investigators point out that penicillin, in addition to being antibacterial for the organism, is excreted rather rapidly in the urine. They found that "between a third and a half of the material is excreted through the urinary apparatus. This is, of course, highly desirable in the treatment of infections of the type being considered. The high degree of solubility of the material also permits it to reach the involved tissues readily."

BUY WAR BONDS

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**OCD ADVISES GAS CLEANSING STATIONS  
AT HOSPITALS**

Hospitals should make complete plans for the immediate establishment, when needed, of "gas cleansing stations" for the care of injured persons who have been exposed to war gases, the Medical Division of the Office of Civilian Defense advises in Operations Letter No. 124 (Supplement No. 4 to Operations Letter No. 42). Large communities should establish at least one gas cleansing station without delay for training purposes.

The OCD recommends that the term "gas cleansing" be used to describe the procedure of removing vesicant liquids from persons and that the term "decontamination" be reserved for areas and objects.

The primary purpose of gas cleansing stations is the protection of hospitals and casualty stations and their staffs and patients from contamination by injured persons who have been exposed to vesicant agents, the Operations Letter points out. Contaminated persons who are not disabled are expected to cleanse themselves in the nearest private home or in other local facilities.

Existing facilities in casualty receiving hospitals must be converted into gas cleansing stations, it is pointed out, since under present conditions of scarcity of materials and manpower, construction of new facilities is generally not justified. Hospital facilities that should prove suitable are suggested as follows: hydrotherapy rooms, nurses' or interns' locker and shower rooms, part of the outpatient department, garages or other separate structures. In the event these are not available, facilities to care for per-

sons who are both injured and contaminated must be arranged in schools, gymnasiums, swimming pools, shower rooms, club houses and community centers.

Cleansing stations should be equipped to take care of from one-third to one-half of the hourly casualty receiving capacity of the hospital to be served, the OCD recommends. The professional staff will consist of mobile medical teams assigned when the station is activated, supplemented by additional attendants from the emergency medical service. In addition to cleansing and emergency treatment, the staff of the gas cleansing station will assist in undressing the injured, moving stretchers, caring for clothing and valuables, maintaining supplies and dressing wounds.

It is recommended that cleansing stations be established at or near hospitals and casualty stations which they are to serve. Every hospital that may be required to handle an appreciable number of casualties should have access to such cleansing station facilities.

The local Chief of Emergency Medical Service is responsible for the development of these stations, with the advice of the Senior Gas Officer of the community.

**REGIONAL MEETING, AMERICAN  
COLLEGE OF PHYSICIANS**

A regional conference of the American College of Physicians was held in Jacksonville, May 26, comprising representatives from four states: Florida, Alabama, Georgia and South Carolina. One hundred seventy-seven physicians were in attendance.

Dr. T. Z. Cason of Jacksonville, Florida governor of the American College of Physicians, presided at the morning session, at which the following program was presented: "Modern Methods of Treating Meningitis," by Col. Henry M. Thomas, Jr., envoy of the Surgeon General, U. S. Army, Atlanta; "Collapse Treatment in Pulmonary Tuberculosis," by Dr. Rollin D. Thompson of Orlando, superintendent and director of the Florida State Tuberculosis Sanatorium; "Some Cardiovascular Problems in Aviation Medicine," by Lieut. Commander Ashton Graybiel of the Naval Air Station, Pensacola.

Dr. Glenville Giddings, Georgia governor of the College, presided at the first afternoon session. Dr. Roy Kracke, professor of pathology, Emory University School of Medicine, Atlanta, presented a paper on "Clinical Importance of the

Rh Factor;" Dr. E. Dice Lineberry, attending physician at Norwood and Hillman Hospitals, Birmingham, spoke on "Peptic Ulcer—Management of Complications." Interesting addresses were also delivered by Dr. Ernest E. Irons, president-elect of the American College of Physicians and attending physician of the Presbyterian Hospital, Chicago, and Major Jere W. Annis of the U. S. Army, officer in charge of gastrointestinal diseases, Station Hospital, Camp Blanding.

Dr. Fred W. Wilkerson, Alabama governor of the College, presided at the final afternoon session. Talks were made by Lieut. Col. William C. Menninger of Atlanta and Dr. William H. Kelly, professor of medicine of the Medical College of South Carolina University.

Dr. Cason was toastmaster at the dinner. Among the speakers were Dr. Irons; Col. Thomas; Col. Menninger; Dr. Charles H. Cocke of Asheville, N. C., a vice president of the American College of Physicians; Dr. Dallas G. Sutton of Washington, D. C., representing the Surgeon General of the U. S. Army; and Edward R. Loveland of Philadelphia, executive secretary of the College.

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Under the plan sponsored by the Board of Past Presidents, the following donations have been received for the purchase of war bonds since the list was published in the April Journal:

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PINELLAS COUNTY	28.75
Herring, John A., St. Petersburg	
Mease, J. A., Dunedin	
SEMINOLE COUNTY	18.50
(From County Society Treasury)	
VOLUSIA COUNTY	25.00
Doern, W. G., Daytona Beach	

#### MEMBERS IN ARMED SERVICES

Names and addresses of doctors in the Armed Services, received since the list was published in the April Journal:

DUVAL	
Thomas, R. Y. H., Jr.	Jacksonville
ESCAMBIA	
Anderson, Egbert V.	Pensacola
RETURNED TO PRIVATE PRACTICE	
DeVore, Louise	Miami
Rotter, Saul D.	Lake Worth

#### BIRTHS AND DEATHS

##### BIRTHS

Dr. and Mrs. Thomas M. Irwin, formerly of Orlando, announce the birth of a son, Edwin Stewart, on March 1, at Jacksonville.

Dr. and Mrs. Hugh A. Carithers of Jacksonville announce the birth of a daughter, Susan, on May 23.

Dr. and Mrs. Walter F. Davey of Stuart announce the birth of a daughter, Susanne, on May 5.

##### DEATHS

Dr. J. H. Pierpont of Pensacola, past president of the Florida Medical Association, died on May 23, 1943.

Dr. Meyer Wigdor of Miami Beach died on May 25, 1943.

Dr. Clifton P. Bullard of Miami died on May 27, 1943.

#### STATE NEWS ITEMS

Dr. Harrison A. Walker of Miami Beach was named medical officer for the Office of Civilian Defense, Fourth Corps Area, Atlanta, Ga., to succeed Dr. Burt A. Dyar who retired on June 1. The announcement was made by Charles H. Murchison, regional director of the Office of Civilian Defense. Dr. Walker's new duties confer on him the rank of lieutenant colonel in the U. S. Public Health Service. He has taken up his new residence in Atlanta.

Dr. Nelson M. Black of Miami and Dr. Shaler Richardson of Jacksonville attended the meeting of the American Ophthalmological Society at Hot Springs, Va., the early part of June.

Dr. J. C. Dickinson of Tampa attended a meeting of the Board of Chancellors of the American College of Radiology in Chicago, June 5 and 6.

A meeting of the Duval County Executive Board for Cancer Control was held at 5 p. m., May 24, at the Riverside Hospital, Jacksonville. Dr. Harry Peyton, chairman of the Board, presided. Other members present were Drs. Gerry R. Holden, Frederick J. Waas, L. Y. Dyrenforth and Kenneth Morris.



The Association of Military Surgeons of the United States will hold its 51st annual convention in Philadelphia at the Bellevue-Stratford Hotel, October 21 to 23, inclusive, according to an announcement by association officers.

The three-day convention will assemble doctors from all of the current war fronts where United States forces are fighting, and from the great base hospitals where rehabilitation of the wounded is in progress. They will bring with them information on the latest technics of wartime medicine and surgery. Numerous forum lectures, practical demonstrations, moving pictures and teaching panels are planned to present the wealth of data to the convention.

Inquiries should be addressed to Captain J. A. Biello, (MC) USN, at the Navy Yard, Philadelphia, Pa.



Stewart Thompson of Jacksonville attended a conference of editors, managing editors and business managers of official journals of state medical associations in Chicago, June 5.



Dr. Roy Ray announces the removal of his office from 114 S. Palmetto Ave. to 227 Orange Ave., Daytona Beach.



Dr. Thomas H. Lipscomb makes the following announcement:

Due to active duty with the United States Navy, I am temporarily withdrawing from private practice. During my absence my colleagues, Dr. H. B. McEuen and Dr. W. McL. Shaw will continue to operate my office for me.

Mrs. Elsie Mackel, technician, will continue to make appointments, do the technical and other nonprofessional work; Dr. McEuen and Dr. Shaw will share the professional burdens of my office.

Dr. McEuen and Dr. Shaw request physicians who have referred patients to me to continue to send them to my office.

I wish to acknowledge my gratitude toward my colleagues who are sacrificing their time without compensation in an effort to maintain my practice during the time I am in the naval service.

## COMPONENT COUNTY SOCIETIES

### DADE

The regular monthly meeting of the Dade County Medical Society was held May 4 at 8:30 p. m., in the library of the Jackson Memorial Hospital, Miami. Dr. Homer L. Pearson, president, presided. Dr. Arthur J. Logie presented a paper on "Tuberculosis," discussed by Drs. E. C. Brunner and Frank L. Quillman. A commercial motion picture on "Plasma Production and Uses" was shown.

### ESCAMBIA

Dr. Neal Owens of New Orleans, associate professor of surgery at Tulane University, New Orleans, presented a paper on "Some of the Newer Developments in the Treatment of Burns," at a meeting of the Escambia County Medical Society held on April 13. Lt. Comdr. Lyle M. Nelson of the Naval Air Station at Pensacola spoke on "Clinical Features of Primary Atypical Pneumonia."

### MANATEE

At a meeting of the Manatee County Medical Society held on May 12, action was taken to co-operate with the local Merchants' Association in observing Wednesday afternoon instead of Thursday afternoon during the summer months as a half holiday. This arrangement will be effective during the months of June, July and August.

### PASCO-HERNANDO-CITRUS

Dr. W. B. Moon entertained the Pasco-Hernando-Citrus County Medical Society at the Magnolia Lodge in Crystal River on May 13. A hearty vote of appreciation was given to Dr. Moon for the full course fish dinner which was served and enjoyed by all present.

Dr. Eugene G. Peek, president of the State Association, a guest at this meeting, delivered a splendid address relating to Association affairs. Dr. W. Wardlaw Jones, the society's delegate to the state convention, made an interesting report concerning the two meetings of the House of Delegates and the General Sessions. Dr. H. F. Watt of Ocala, also a guest, gave an interesting talk.

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Attending the meeting were Drs. J. T. Bradshaw, San Antonio; G. R. Creekmore, Brooksville; S. C. Harvard, Brooksville; W. B. Moon, Crystal River; W. H. Walters, Lacochee; Eugene G. Peek and H. F. Watt, Ocala.

#### PINELLAS

The regular monthly meeting of the Pinellas County Medical Society was held on the evening of May 7 at the Army and Navy Club, St. Petersburg. Two papers comprised the scientific program: "Peritendinitis Calcarea" by Dr. Annette M. Feaster, and "Headache" by Dr. M. A. Nickle.

#### POLK

A clinical program was presented at a meeting of the Polk County Medical Society held at the County Hospital, Bartow, on May 12. Drs. H. J. Jensen of Lakeland, H. R. Mills of Tampa and E. E. Sawyer of Bartow led the discussions. Dr. E. F. Hoffman of the Bureau of Epidemiology of the State Board of Health, and Dr. Lawrence M. Zell of the U. S. Public Health Service in charge of venereal disease control in the county, were guests at this meeting. Dr. T. G. Simmons of Auburndale, president, presided.

#### ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN

The St. Lucie-Okeechobee-Indian River-Martin County Medical Society has paid 100% of its dues for the current year. Officers of this society are Dr. F. A. Gowdy, president; Dr. M. D. Council, vice president, and Dr. A. M. Sample, secretary-treasurer.

#### SEMINOLE

Members of the Seminole County Medical Society and medical personnel of the air base were invited to the home of the president, Dr. George H. Putnam, for the evening of April 13, 1943. After an enjoyable buffet supper, President Putnam called the meeting to order. Dr. R. S. Widmeyer was the first speaker; Dr. W. L. Stallworth discussed a recent case of Bandl's Contraction; Dr. J. A. Smith discussed medical practice in the North; and Dr. Putnam presented two cases for discussion. After each speaker's address, the members took part in a general discussion.

Dr. Leland H. Dame, secretary, reported that Dr. W. T. Langley had been elected an honorary member of the State Association. Dr. J. A. Smith, recently of West Virginia, and now located in Sanford, was invited to join the society.

#### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

#### NEUROLOGICAL COMPLICATIONS OF SERUM SICKNESS WITH SPECIAL REFERENCE TO THE EAR, TAYLOR, H. MARSHALL, JACKSONVILLE, LARYNGOSCOPE 52: 923 (DEC.) 1942.

A case of permanent nerve deafness owing to an anaphylactic reaction resulting from the administration of tetanus antitoxin is reported.

A man in good health was given a prophylactic dose of tetanus antitoxin within two hours after receiving a laceration of the finger. Five days later a general anaphylactic reaction developed, followed in six hours by a permanent bilateral deafness of high degree, associated with vestibular changes of a degenerative type.

The pathologic changes which cause deafness from an anaphylactic reaction are not quite clear. According to one theory the deafness results from a diffuse serous labyrinthitis with partial destruction of the function of both parts of the labyrinth. Another explanation that may be considered is the compression neuritis similar to that of Bell's facial paralysis.

In the case reported there also arose the question of previous sensitivity, for the patient had been given tetanus antitoxin prophylactically seven years before. The author points out that undoubtedly many complications of serum sickness go unrecognized. Some of the deafness following various types of meningitis may, likewise, be caused by large doses of serum used rather than by actual pathologic changes engendered by the meningitis.



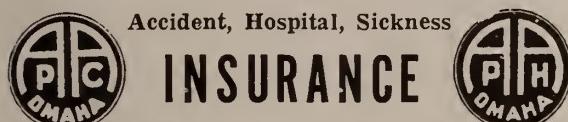
#### PRELIMINARY REPORT ON PARA-AMINOBENZOIC ACID FOR GRAYING HAIR, DEVILBISS, LYDIA ALLEN, MIAMI, MED. WOMAN'S J. 49: 341, 351 (Nov.) 1942.

Reviewing the studies of Sieve, Ansbacher and others, para-aminobenzoic acid therapy for graying hair is reported by the author. Fourteen patients were treated and the results recorded. Photographs, both in color and in black and white, were made before and after treatment.

Four 100 mgm. tablets of para-aminobenzoic acid (filtrate factor vitamin B complex) were given daily for from two to seven months. In all cases reported, after treatment of varying

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MEDICINE—Two Weeks Intensive Course starting October 4. One Month Course in Electrocardiography and Heart Disease starting the first of every month, except August. Two Weeks Course in Electrocardiography starting August 2.

FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course starting October 18.

GYNECOLOGY—Two Weeks Intensive Course starting October 18. One Month Personal Course starting August 2. Clinical and Diagnostic Courses.

OBSTETRICS—Two Weeks Intensive Course starting October 4.

OPHTHALMOLOGY—Two Weeks Intensive Course starting September 27. Course in Refraction Methods October 11.

OTOLARYNGOLOGY — Two Weeks Intensive Course starting September 13.

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Extrusion	POSTOPERATIVE	BREAST
Kyphosis	Appendectomy	Amputation
Lordosis	Cesarean Section	Mastitis
Lumbosacral Sprain	Cholecystectomy	Nodules
Nephroptosis	Colostomy	Nursing
Obesity	Herniotomy	Prenatal
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Postpartum	Nephrectomy	Ptosis
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duration, visual darkening of new grown hair, and in some instances restoration to the original color, resulted. No ill effects were observed except in one case, in which intense sweating occurred.

**TRAUMA AND GLOMUS TUMORS; RELATIONSHIP,  
WITH REPORT OF A CASE, LOEB, MARTIN J.,  
NEW YORK, INDUST. MED. 10: 208-213  
(MAY) 1941.**

A glomus is defined as a thermo regulatory organ located in any part of the skin, particularly on the hands, feet, and under the nails. It acts as a regulator of the local and systemic temperature. The glomus is a neuromuscular-arterial organ, controlled by the sympathetic nervous system. Glomus tumors usually occur in the extremities, but may develop anywhere in the body. They vary in size from 2 to 20 mm. in diameter. The tumor may be purple or rose-colored, and is regarded as an exaggerated normal structure instead of a new growth. Stout described it as a small mass of blood vessels enclosed within a capsule. The vessels are endothelial-lined, and the wall is made up of peculiar cuboid or rounded "glomus" cells and smooth muscle. Also present are myelinated and non-myelinated nerve fibers.

The most important symptom of glomus tumor is constant pain, which may be localized to the area of the tumor or radiate toward the body. Slight touch, change of temperature, particularly cold, may cause a paroxysm of pain lasting from several minutes to hours.

In the case described by the author, the patient was a machinist, 31 years of age, whose left ring finger had been squeezed between two plates of a machine, from which time he had suffered pain in that finger on the slightest touch. The pain was more severe during the winter and occasionally paroxysms in the left shoulder lasted from one to several minutes. On physical examination a small purple spot, the size of a pinhead, was observed under the nail of the injured finger. Under local anesthesia a small tumor was excised. Microscopic examination of the tumor revealed an arterial angioneuromyoma of Masson. When seen two years later, the patient stated that he was able to work and had no abnormal sensitiveness in the finger.

Statistics submitted by the author reveal that in 20.85 per cent of 144 cases studied, there was an antecedent history of trauma.

**BOOKS RECEIVED**

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

**THE INNER EAR.** By Joseph Fischer, M.D., Staff Member, Beth Israel Hospital, Boston; and Louis E. Wolfson, M.D., Instructor in Ear, Nose and Throat, Tufts Medical School, Boston. The authors have succeeded in putting into printed text the fruitful demonstration method of clinic and conference—the one out of his years of clinical lecturing and group discussion in world-famous European medical centers, the other from the results of systematic observation and participation in foremost technical advances in this country. Both authors reflect a rich background of study and personal association with the famous leaders who established the landmarks of modern otologic science. Cloth. Price, \$5.75. Pp. 439, with 79 illustrations. New York: Grune and Stratton, 1943.

**FLYING MEN AND MEDICINE.** By E. Osmun Barr, M. D., member surgical staffs of Emergency and Doctors Hospitals, Washington, D. C. This is the story of the forces at work on the body when you travel through the air at great speed or when you go high above the ordinary atmospheric conditions of life on the ground. If you want to become a pilot, these pages will inform you on the procedure that is followed in the examination which you must take and why that examination is made. Air medicine is new; your knowledge of its fundamentals will assist you no end in obtaining your wings and keeping them. The contents of this book on medicine and the airman will enable you to become a flyer more quickly and to stay in the air longer. Cloth. Price, \$ 2.50. Pp. 270, with illustrations. New York: Funk and Wagnalls Company, 1943.

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enjoy a refreshing glass of beer . . . in the company of good friends . . . with wholesome American food . . . as a beverage of moderation after a good day's work.

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Little things that help to lift the spirit, keep up the courage. Little things that are part and parcel of our own American way of life.

And, after all, aren't they among the things we fight for?

**MORALE IS A LOT OF LITTLE THINGS**

*(as you, Doctor, know better than most)*



## ADVERTISERS' NOTES

## PEDIATRIC ANTIQUES ON TOUR

It has been well said that more progress has been made in pediatrics during the past three or four decades than in all the time before that.

As applied to the feeding part of pediatrics, the Mead Johnson Collection of Pediatric Antiques bears eloquent witness to the great strides made. Without such evidence, it would be difficult, indeed, to imagine our own grandparents being fed from some of these odd-shaped utensils that defied thorough cleansing. To be sure, sterilization and pasteurization were not then in vogue. Not all babies received breast milk in abundance. In the days when wet nurses were common, some of these enterprising women literally did a wholesale business, managing to nurse three or four infants.

The baby's cereal of a century ago was simply stale bread lightly boiled in water, wine or beer. Butter or sugar might be added but the use of milk was regarded as fraught with danger. It was thought, according to Dr. T. G. H. Drake, "Milk might bring on the watery gripes, or the infant might imbibe with the milk the evil passions and frisky habits of the animal supplying the milk."

From a personal hobby enjoyed by the late E. Mead Johnson, Jr., the Collection of Pediatric Antiques, illustrated in the pages of a catalogue just issued, has evolved into one of considerable historical importance, depicting as it does the progression of infants' feeding vessels from the Greece of twenty-five centuries ago down to time within our own memory.

The Collection has been steadily growing in size and scope and is of increasing interest for teaching purposes via the historical route. The destruction of original sources caused by the war tends to add to the value of these objects.

Hence it is that, by request, the Collection now goes on an annual pilgrimage to colleges, hospitals, museums, libraries and other institutions of learning. Arrangements may be made for "stop-overs" upon application to the curator. Mead Johnson & Company, Evansville, Indiana, U.S.A.

## MORE HELP FOR MILK-ALLERGIC PATIENTS

Appetizing and nutritious recipes for using Mull-Soy in milk-free diets are now available in a new publication from Borden's Prescription Products Division. Already widely prescribed as a hypoallergenic substitute for milk in infant formulas, Mull-Soy is now proving equally useful in diets of older infants, children and adults who are allergic to milk.

Mull-Soy is an ethically-marketed soybean food in liquid emulsified form. It is palatable, readily digestible, well-tolerated, and easy to use. Although hypoallergenic in most cases of milk allergy, it nevertheless closely resembles milk in nutritional values of protein, fat, carbohydrate, and minerals. Mull-Soy ingredients are entirely of non-animal origin, consisting of soybean flour, soybean oil, soybean lecithin, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and water. After special processing at carefully controlled temperatures, the mixture is homogenized at high pressure, sealed in sanitary-type cans, and sterilized. In flavor it is slightly sweet and nutlike, and many find it makes a pleasing warm drink when simply diluted with an equal amount of hot water.

Included in the new Mull-Soy recipe folder are numerous beverages, soups, and desserts, as well as directions for using Mull-Soy in place of milk or cream for cereals, coffee, mashed potatoes, etc. Each recipe has been carefully tested in the Borden Experimental Kitchen and checked for palatability, ease of preparation, and suitability for milk-free allergy diets. A number of the recipes have several suggested variations and optional ingredients which permit greater variety in the diet and

also make the recipes more useful for patients allergic to other foods in addition to milk.

These Mull-Soy recipe folders are designed for distribution by physicians to their patients. Any desired number of copies may be obtained by writing to Borden's Prescription Products Division, Department CB, 350 Madison Avenue, New York, 17, N. Y.

## TESTING COLOR PERCEPTION

In recent months the subject of color blindness has received considerable attention in professional circles. As another indication of the wide interest in color vision, American Optical Company reports that thousands of its Pseudo-Isochromatic Plates for testing color perception have been distributed to the U. S. Army and Navy, and the Royal Canadian Air Force, for use in testing the eyes of recruits.

Creation of this AO color test by the United States Navy was inspired when accurate Japanese and German tests became increasingly hard to procure. Forty-six test plates have been compiled and bound in strong, blue cloth covers. Printing of the plates was a notable achievement. No less than 93 different colors were needed and 140 separate colors were matched during preparation of the printing operation. The 46 plates average a maze of seven colors in each.

The plates are arranged so that malingerers are quickly detected and ordinary red and green cases of color blindness and the rarer blue-blindness may be discovered by using not more than two or three charts. Weakness in color perception may be indicated by the test. Despite this simplicity of method, the 46 plates are so comprehensive that children, illiterates and even deaf mutes may be examined accurately. An instruction handbook accompanies each test.

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**A WORD OF GREETING TO AUXILIARY MEMBERS***Dear Co-workers:*

In this issue of the State Journal, you will see that your officers and chairmen of last year are still, or shall I say, again, your leaders for the coming year. This, as you no doubt know, is due to conditions prevailing during war times. As we are willing to hold together for the good functioning of our organization, so we are asking you to hold together. Never before in our short history has it been so necessary to achieve unity of thought and action. May I urge you to keep this always in mind during the coming months.

In the near future you will receive the charges for the coming year. These charges, prepared by our advisory board, should serve as a guide for your year's work. Follow these charges as closely as possible. Notice the stress placed on defense work. Give it your full attention.

May I ask auxiliaries that have not sent in new lists of officers, to do so at once. Send addresses with names, please.

Begin early to get subscriptions for the Bulletin. Appoint an active Bulletin chairman. Read your Bulletin and inform yourselves concerning the vital work done by your organization.

Keep in touch with members absent temporarily because of the war. Let them know they are not forgotten.

I am looking forward to the opportunity and pleasure of going to the National Convention in

Chicago as your state president. It is really an honor and a privilege. Upon my return I shall give you a brief account of the events of that meeting.

May I take this opportunity again to thank the Duval County Auxiliary, especially the president and her co-chairmen, for so graciously entertaining the State Auxiliary in April. Such entertainments are no small matter in these times.

I wish for each of you a happy summer. Nothing can be gained by despair, so keep your hearts and minds hopeful no matter what betides. There is a loving hand guiding our destiny. Work for a good today and a better tomorrow and the better tomorrow will be with us sooner than we anticipate.

LYDIA KRUEGER (MRS. F. W.)

*President*

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212 West Franklin Street (Corner of Madison) RICHMOND, VIRGINIA



Private Hospital for neurological cases under the charge of Drs. Beverley R. Tucker, Howard R. Masters and James Asa Shield. Department of Physiotherapy.

STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Eugene G. Peek, Ocala.....	Shaler Richardson, Jacksonville.....	To Be Announced
Florida Medical Districts: —Northwest .....	Courtland D. Whitaker, Marianna L. Y. Durenforth, Jacksonville....	Stewart Thompson, Jacksonville..... " " "	Tallahassee, Postponed
—Northeast .....	Edgar Watson, Lakeland.....	" " "	Ocala, Postponed
—Southwest .....	William Y. Sayad, W. Palm Beach..	" " "	Sarasota, Postponed
—Southeast .....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	Miami, Postponed
Alabama Medical Association.....	James A. Redfearn, Albany.....	E. D. Shanks, Atlanta.....	Atlanta, May 11-14, 1943
Georgia, Medical Assn. of.....	R. H. Knowlton, St. Petersburg....	Kenneth Phillips, Miami .....	To Be Announced
Florida—	A. Malcolm Smith, D.D.S., Tampa.....	H. L. Cartee, D.D.S., Miami.....	To Be Announced
Florida Society, State.....	Wiley M. Sams, Miami.....	Lauren M. Sompayrac, Jacksonville.....	Miami, October, 1943
Florida and Syph., Soc. of.....	T. C. Kenaston, Cocoa.....	I. M. Hay, Melbourne.....	Postponed
East Coast Medical Association.....	Mr. W. E. Arnold, Jacksonville.....	Miss Katharine Moyer, Lake Wales.....	
Florida Hospital Association.....	Frank D. Gray, Orlando.....	Richard H. Walker, Orlando.....	To Be Announced
Florida Industrial Surgeons, Assn. of.....	Turner Z. Cason, Jacksonville.....	Chairman	
Florida Medical Postgraduate Course.....	Mrs. Ann Thompkins, Leesburg.....	Miss Madalee Hazel, St. Petersburg.....	To Be Announced
Florida Nurses Association, State.....	Shaler Richardson, Jacksonville.....	C. E. Dunaway, Miami.....	To Be Announced
Florida Ophthalm. & Otol., Soc. of.....	L. Y. Durenforth, Jacksonville....	Iva C. Youmans, Miami.....	To Be Announced
Florida Theological Society.....	Ludo von Meysenbug, Daytona B.....	Robert Blessing, Ft. Lauderdale.....	To Be Announced
Florida Pediatric Society.....	Mr. H. B. Douglas, Bonifay.....	Mr. R. Q. Richards, Ft. Myers.....	Miami, To Be Announced
Florida Farmaceutical Association, State.....	Leland H. Dame, Sanford.....	E. M. L'Engle, Jacksonville.....	
Florida Public Health Association.....	John N. Moore, Ocala.....	Walter A. Weed, Orlando.....	To Be Announced
Florida Radiological Society.....	Frank D. Gray, Orlando.....	W. C. Page, Cocoa.....	To Be Announced
Florida Hospital Surgeons' Association.....	Mrs. M. M. Ebert, Lake Wales.....	Mrs. May Pynchon, Jacksonville.....	Jacksonville, May, 1943
Florida Tuberculosis & Health Assn.....	Herbert E. White, St. Augustine.....	Robert B. McIver, Jacksonville.....	Postponed
Florida Panhandle Valley Med. Assn.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	Postponed
Florida Coast Clinical Society.....	John J. McGuire, Pensacola.....	Kenneth Phillips, Miami.....	
Florida Sec., Am. Cong. Phys. Ther.....	Alton Ochsner, New Orleans.....	B. T. Beasley, Atlanta.....	Postponed
Florida Eastern Surgical Congress.....	Harvey F. Garrison, Jackson, Miss.....	Mr. C. P. Loranz, Birmingham.....	Cincinnati, Nov. 16-18, 1943
Florida Unne River Medical Society.....	L. J. Arnold, Jr., Lake City.....	H. S. Howell, Lake City.....	

**COMPONENT SOCIETIES BY DISTRICTS**

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	J. Powell Adams, M.D. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		14	12	A-1-45 C. D. Whitaker, M.D. Marianna
Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	49	48	
Franklin-Gulf		J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	5	100%	
Jackson *Calhoun	R. N. Joyner, M.D. Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	13	100%	
Walton-Okalooza	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	6	100%	
A Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	100%	
Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	James W. Sapp, M.D. Havana	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 8:00 P.M.	40	37	
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		7	100%	
Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	G. H. Warren, M.D. Perry	Last Friday 8:00 P.M.	5	4	
Alachua *Bradford, Gilchrist, Union	Geo. C. Tillman, M.D. 505 W. University Gainesville	Chester F. Ahmann, M.D. 1043 W. Masonic Gainesville	2nd Wednesday 7:30 P.M.	28	25	B-3-45 L. V. Dyrenforth, M.D. Jacksonville
Duval *Clay	T. Z. Cason, M.D. 2033 Riverside Ave. Jacksonville	F. A. Copp, M.D. 411 St. James Bldg. Jacksonville	1st Tuesday 8:15 P.M.	195	193	
Marion *Levy	T. Hartley Davis, M.D. 202 Commercial Bk. Bldg. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	29	27	
Nassau	Geo. A. Dame, M.D. Fernandina	E. F. Waite, M.D. Fernandina	2nd Wednesday 8:00 P.M.	9	100%	
Putnam	J. Worth Brantley, M.D. Grandin	C. M. Knight, M.D. Palatka	2nd Tuesday Even Months 7:00 P.M.	9	100%	
St. Johns	Alfred W. Norris, M.D. Flagler Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	G. E. Christie, M.D. Box 151 Titusville	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	100%	
Lake *Sumter	Louis R. Bowen, M.D. Eustis	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	100%	
Orange *Osceola	T. E. McBride, M.D. Apopka	John A. Pines, M.D. 106 E. Central Ave. Orlando	3rd Wednesday 8:00 P.M.	93	83	
Seminole	Geo. H. Putnam, M.D. Touchton Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	11	100%	
Volusia *Flagler	L. von Meyenburg, M.D. Box 3356 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	44	37	
Hillsborough	T. C. Maguire, M.D. 104 S. Collins St. Plant City	James S. Grable, M.D. 811 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	106	95	C-5-44 Leland F. Carlton, M.D. Tampa
Manatee	M. M. Harrison, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	14	100%	
Pasco-Hernando- Citrus	W. W. Jones, M.D. Dade City	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	11	100%	
Pinellas	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	Annette M. Feaster, M.D. 166 Fourth Ave. N. E. St. Petersburg	1st and 3rd Fridays 6:30 P.M.	104	100	
Sarasota	O. H. Cribbins, M.D. 138 N. Link Sarasota	A. O. Morton, M.D. Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	20	100%	
DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	100%	C-6-45 Edgar Watson, M.D. Lakeland
Lee *Collier, Hendry	H. Quillian Jones, M.D. 18 Leon Bldg. Fort Myers	W. H. Grace, M.D. Box 907 Fort Myers	3rd Tuesday 7:30 P.M.	17	16	
Polk	T. G. Simmons, M.D. Corlett Bldg. Auburndale	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	62	100%	
Palm Beach	K. Montgomery, M.D. Guaranty Bldg. W. Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	4th Monday 8:00 P.M.	68	62	D-7-45 William Y. Sayad, M.D. West Palm Beach
St. Lucie- Okeechobee-Indian River-Martin	Francis A. Gowdy, M.D. Box 745 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	100%	
Broward	D. W. Harris, M.D. 420 Sweet Bldg. Ft. Lauderdale	O. C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	2nd Wednesday 8:00 P.M.	42	100%	
Dade	H. L. Pearson, M.D. 416 Ingraham Bldg. Miami	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami	1st Tuesday 8:30 P.M.	343	317	
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P.M.	5	100%	

\*Supervise and aid until organized separately.

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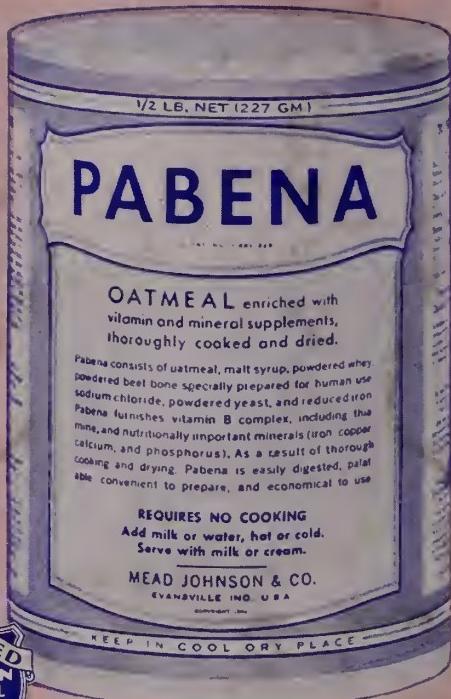


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Vol. XXX

AUGUST, 1943

No. 2

THE N.Y. ACADEMY  
OF MEDICINE

AUG - 8 1943

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## The Journal of the Florida Medical Association

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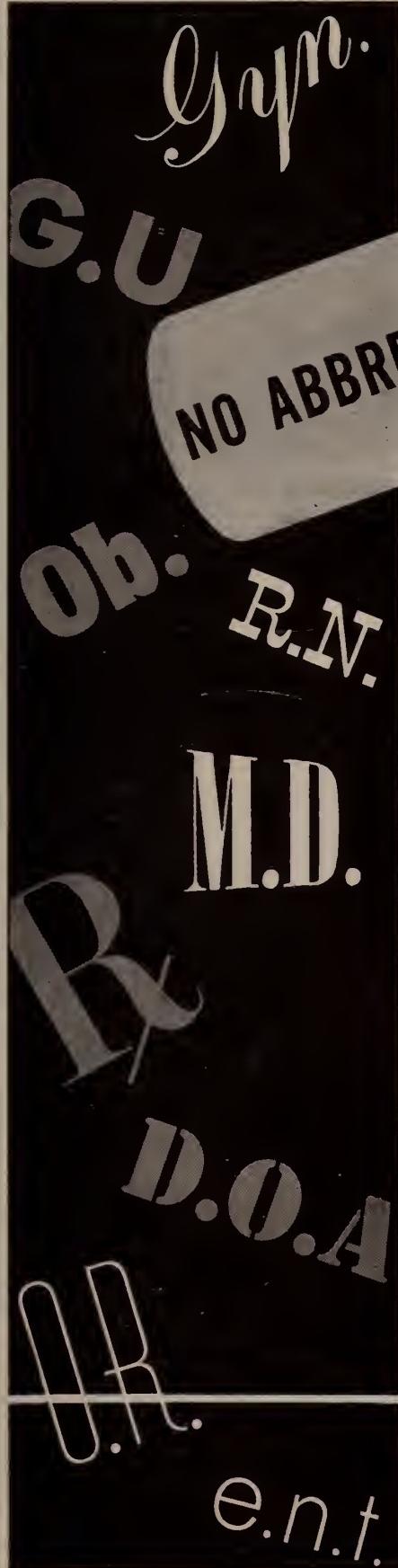
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\**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154. *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60.  
*Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241. *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592



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## RENAL TUBERCULOSIS

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Tuberculosis of the kidney is often unrecognized during life, and it is therefore necessary to refer to autopsy records in order to obtain an idea of its prevalence. Chambers, Morris and Brown<sup>1</sup> studied the records of 5,330 cases that came to autopsy and noted that tuberculosis of the kidney was present in 2.95 per cent of these cases. Schlesinger and Heidrich<sup>2</sup> stated that about 5 per cent of all bodies give evidence of tuberculosis of the urinary tract at autopsy. These figures are all approximate since the number of cases in relation to the general population depends entirely on the number of cases of tuberculosis present in the region concerned, and the number of cases in relation to the total number of cases of tuberculosis depends, as will be shown later, largely upon the care which is taken in the search for tuberculous foci in the kidneys.

Tuberculosis of the kidney appears mostly in early middle life, between the ages of 20 and 40. It is regarded as comparatively rare in children, but probably many cases are not diagnosed. Wildbolz<sup>3</sup> quoted a number of figures from different writers showing that evidence of renal tuberculosis is much more commonly observed at autopsy in children than the clinical records would lead one to believe.

The distribution as to sex is somewhat difficult to determine, since the practice of various surgeons is apt to be limited more or less to one sex or the other. In general, however, according to the collected statistics of Wildbolz,<sup>3</sup> about twice as many women as men are operated upon.

Braasch and Scholl<sup>4</sup> were able to demonstrate pulmonary tuberculosis in 28 per cent of their cases of renal tuberculosis. There is little doubt that in many cases pulmonary lesions are present which cannot be definitely demonstrated. These authors also agreed that tuberculosis of the bone or joints occurs in about 6 or 7 per cent of the cases.

It is evident from all statistics that renal tuberculosis is a highly fatal disease when not

treated. One author<sup>2</sup> stated that 58 per cent of 316 untreated persons died within five years, while only 6 per cent lived more than ten years.

When the genital tract is involved in men, the prognosis becomes much more serious, and the chances for successful treatment are reduced. Statistics show that the end results of untreated cases are little better, if any, in women than in men. But, as will appear later, the results of surgical treatment are much better in women because of the absence of genital complications.

## MODES OF INFECTION

In a large number of cases it is impossible to demonstrate the lesion serving as a portal of entry for renal tuberculosis, but it is obvious that the kidney cannot be infected unless the bacilli enter the body elsewhere. It has been claimed that they may do so through the respiratory or the alimentary tract without causing any lesion, but in view of many recent researches these channels seem extremely unlikely. The lesion, however, may be very small and difficult, if not impossible, to find even at autopsy. The infection usually reaches the kidney through the blood stream.

The kidney is practically always the first organ involved in the urinary tract in women, but in men the genital tract is the first involved in at least one-half the cases of urogenital tuberculosis. When the male genital tract is involved before the kidney, the kidney is often secondarily involved. This is a fact which should be much more widely known, since surgical treatment of genital tuberculosis in the presence of an unrecognized lesion of the kidney is bound to be fruitless. This secondary involvement of the kidney often follows extension to the bladder, and it may well be that in some cases the infection ascends the ureter through the lymphatics and reaches the kidney in this manner. On the other hand, it is possible that the lesions of genital tuberculosis may feed bacilli into the blood stream just as any other tuberculous lesion may, and that the secondary renal infection may occur by this means.

## PATHOLOGY

The great majority of all observers have come to the conclusion that renal tuberculosis is al-

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ways, at the beginning, a unilateral disease. The fact that complete restoration to health occurs in many patients after nephrectomy is perhaps the most important reason for this conclusion. There is, however, no question that bilateral infection is not infrequently observed, and it is apparently true that in cases in which no operation is performed, the second kidney is apt to become involved at some later date.

Young and Davis<sup>5</sup> noted the presence of bilateral infections in 17.5 per cent of 205 cases, but it is noteworthy that in 81 per cent of these cases of bilateral infection, all of which occurred in men, there was, in addition, involvement of the genital tract. Medlar,<sup>6</sup> who made extraordinarily thorough studies in his cases, examining thousands of serial sections, reported both kidneys involved in all cases, but the lesions in the presumably healthy kidney were very small and often invisible to the naked eye. That they were tuberculous, however, is proved by the fact that tubercle bacilli were found within them. Consideration of this striking piece of work causes one immediately to bring up two questions which have often been asked in relation to tuberculosis of the kidney:

1. Can tubercle bacilli be excreted by the kidney without infection?
2. Can tuberculous lesions of the kidney ever heal?

The first is of importance because in certain cases, although the material from the apparently sound side has produced positive guinea pig tests, the patients nevertheless become well after nephrectomy. It has been assumed by some that this result may represent contamination of the ureteral catheter while passing through the infected bladder. Others have assumed that tubercle bacilli pass through an entirely intact kidney. The most thorough and most recent studies<sup>5, 6, 7</sup> all indicate that no kind of bacteria can pass through the intact kidney.

The observations of Medlar<sup>6</sup> were that 75 per cent of the lesions discovered are in the cortex and 11 per cent in the medulla, while 13 per cent involve both regions. Cortical lesions are usually small and show a definite tendency to heal. The medullary and corticomedullary lesions, on the other hand, particularly if they occur, as they usually do, in the region of the arcuate vessels, tend to grow larger and ultimately involve all the renal tissue in the area subtended by the original lesion. For this reason they are less

apt to be encapsulated and they constitute the great majority of tuberculous lesions of the kidney. The products of these lesions are discharged into the bladder where they set up a cystitis, and unless this condition occurs, tuberculosis of the kidney is usually symptomless and therefore escapes observation.

The earliest microscopic picture is that of a round cell infiltration followed shortly by the appearance of epithelioid cells. This may be succeeded by fibrosis and healing, but if the defensive forces are overcome, necrosis occurs in the middle of the involved area. In this event a polymorphonuclear reaction takes place, and a small tuberculous abscess occurs. During all these early stages leukocytes and bacilli are found in the tubules leading from the lesion, particularly after necrosis has begun, so that it is not necessary for the ulceration to extend into a calix for pus and bacilli to appear in the urine. As the lesions advance, however, the ulceration extends in the direction of the pelvis more rapidly than toward the periphery, and once this communication is established, there is a free outlet for the products of inflammation. It seems likely that spread occurs by means of the pelvis, since in the late stages there may be in the kidney a number of caseous foci producing the so-called renal phthisis in which the secreting tissue of the kidney is entirely destroyed. In some cases these cavities apparently empty themselves of caseous material and become filled with pus, which condition is spoken of as tuberculous pyonephrosis. In other cases implantation of the infection occurs in the pelvis and ureters, giving rise ultimately to ureteral obstruction. When this happens, true hydronephrosis is superimposed on the tuberculous process. This condition may be converted into a pyonephrosis. Careful study will serve to differentiate the two varieties of pyonephrosis.

Miliary tuberculosis concerns the surgeon but little. The tubercles are usually more numerous, and both kidneys are about equally involved, but the microscopic picture is the same. The evolution of the disease would probably be similar were it not that death usually occurs at an early stage.

Tuberculosis of the bladder is the most common complication and first takes the form of multiple and sometimes confluent areas of inflammation, followed later by shallow ulceration, which is characteristically serpiginous in outline. Sections at this stage show an inflammation

which is essentially nonspecific in character, and bacilli are difficult or impossible to demonstrate. Such lesions usually heal after removal of the offending kidney. Similar lesions occur in the ureter, and in the bladder they are often observed near the ureteral orifice of the affected side. They may, however, be on the opposite side of the bladder. In later stages true tubercles may develop in the wall of the bladder, in which case healing no longer occurs after the kidney is removed. The same is true of the ureter.

Secondary infection with common organisms may occur in a tuberculous kidney either spontaneously or as a result of instrumental intervention. Calculi may develop in the tuberculous kidney, and if they cause obstruction, the complication is serious. Calcareous deposits occur in the fibrous walls of the cavities in advanced cases and are to be distinguished from true stones.

In male patients, the most serious complication of renal tuberculosis is tuberculosis of the genital tract. Genital involvement usually occurs by way of the prostate and seminal vesicles, with the epididymis involved last, but in some instances epididymal tuberculosis may appear first, indicating a transmission from the kidney by means of the blood stream.

#### SYMPTOMS

Renal tuberculosis is, in itself, in most cases practically a symptomless disease until the late stages. Among the 205 renal cases reported by Young and Davis,<sup>5</sup> pain in the kidney was noted as the first symptom in only 44. When symptoms appear, they are usually entirely referable to the bladder, and in many cases long series of treatments of the bladder are given before the correct diagnosis is suspected.

Frequency of urination, usually accompanied by burning, is the form which the irritability of the bladder usually takes at first. Hematuria is the next most important cardinal symptom. In a large number of cases frequency and hematuria begin simultaneously, or within a short time of each other, so much so that the conjunction of these two symptoms should certainly always cause one to suspect tuberculosis. The bleeding of malignant disease usually begins before there is frequency, while the frequency of obstruction is scarcely ever accompanied, in its early stages, by bleeding. Loss of weight occurs in a goodly percentage of cases, and chills, fever, and night

sweats were noted in 22.5 per cent of the cases of Young and Davis.<sup>5</sup>

The symptoms referable to the bladder are usually progressive, and to frequency of urination are later added pain, urgency and tenesmus. The pain in the bladder may become constant, although it is usually accentuated by the act of voiding. The frequency may become so great that urine is being voided practically continuously, giving a false incontinence. The physical and mental anguish, together with loss of sleep, reduce the victims to a desperate condition. The pain in the kidney is usually a more or less constant aching, but renal colic may occur, usually occasioned by the passage of blood clots.

If ureteral obstruction occurs, the symptoms of hydronephrosis are added to those already mentioned, and it is in cases of this type that a noticeable tumor is most apt to be present. When the disease becomes bilateral, renal symptoms may be noted on both sides, or there may be no symptoms except those related to the bladder until the symptoms of uremia begin to appear. Miliary tuberculosis may rarely occur, but is more apt to supervene as a sequel to surgical intervention.

#### DIAGNOSIS

The history of patients with renal tuberculosis often reveals the presence of tuberculosis in other members of the family, and in the patient the symptoms of pre-existent pulmonary tuberculosis or other forms of the disease, loss of weight, night sweats and other suggestive manifestations. Persistent fistulas of the scrotum or of the urethra, provided no urinary obstruction is present, are extremely suggestive of tuberculosis. Careful examination of the regions about the kidney may, in a few cases, disclose a mass of tenderness where no renal pain had been noted before. The testes and epididymides should be examined with greatest care since genital involvement is frequent, and in some cases entirely unnoticed by the patient. Palpation of the prostate and seminal vesicles should be thorough, and the presence in a young person of irregularities, nodules and extreme induration of the prostate or seminal vesicles is particularly significant and usually indicates tuberculosis. In older men carcinoma of the prostate is the common cause of these conditions, but they are sometimes due to tuberculosis and give rise to serious errors in diagnosis.

Most important is the study of the urine. An

especially valuable sign here is the presence of pus when no bacteria can be demonstrated by the ordinary methylene blue or Gram stain, or by culture. This indication, particularly if red blood cells are also present, should always cause one to suspect tuberculosis. The finding of ordinary bacteria does not rule out tuberculosis, since they may be present as a secondary infection. Blood should always be looked for under the microscope, as it is often present when there is no gross hematuria.

Staining the urine for tubercle bacilli is a most important step in the procedure. They are usually present in cases of renal tuberculosis and, if found, fix the diagnosis beyond dispute. Repeated efforts and long search may be necessary to find them. The smegma bacillus, which is also acid-fast, may give rise to confusion, but may easily be eliminated by cleansing the external genitalia and irrigating the urethra before obtaining a specimen. The urine must be centrifuged for a long time and the sediment obtained from the bottom of a conical centrifuge tube with a platinum loop must then be spread in a fairly thick layer on the slide. The use of the Ziehl-Neelsen carbolfuchsin stain is usually the method of choice. The preparation may be boiled for one minute, steamed for five minutes, or left in a cold stain overnight.

If tubercle bacilli cannot be demonstrated in this way, some of the urinary sediment should be injected in a guinea pig, either intraperitoneally or subcutaneously in the groin. The latter is the method of choice when other bacteria are present. A period of from three to six weeks is required for the development of unmistakable lesions, which are then demonstrated by dissection of the guinea pig.

Cystoscopy is essential in the proper diagnosis of renal tuberculosis. The most characteristic finding in the bladder is that of the typical shallow, serpiginous, tuberculous ulcer, surrounded by a halo of inflammation. In some cases tubercles themselves may be seen as small, opaque, yellow, slightly elevated papules, also with a zone of inflammation. The most common location of these lesions is on the trigone and in relation to the ureter of the affected side. In addition, there may be a diffuse acute cystitis with congestion and edema. In cases of extensive involvement of the ureter it may be shortened to an extent which pulls up the corresponding corner of the trigone, and this shortened

ureter may transmit to the trigone the respiratory movements of the diaphragm, causing it, as noted by Young and Davis,<sup>5</sup> to move up and down with respiration.

In late stages the bladder may be greatly contracted, making cystoscopy difficult, with extensive ulceration, edema, and masses of mucus, pus, blood clots, slough, or granulation tissue obscuring all landmarks and making discovery of the ureteral orifices extremely difficult or impossible. In these cases it is always mandatory to use sacral or a general anesthesia for a satisfactory examination.

Catheterization of the ureters is of the utmost importance, first to discover which is the affected side, and secondly to determine the state as to function and tuberculous infection of the supposedly healthy side. Indigo carmine is the best dye for determination of function and will give, in a general way, an idea of the extent to which the kidney has been damaged by the tuberculous process. The investigation of the opposite side is a matter of great interest. A guinea pig test of urine from the healthy kidney should always be done before one performs a nephrectomy.

Hymann<sup>6</sup> reported the guinea pig test positive when made for the sound side in 18 per cent of his cases, but he performed nephrectomy in spite of this reaction, with good results. Ordinarily the finding of bacilli in specimens from the supposedly sound side would be considered a contraindication to operation, but it now appears that the question must remain an open one and be decided in each case according to the best judgment of the surgeon. The functional test is undoubtedly of considerable importance in making this decision. If the total function is subnormal, one may safely assume that both kidneys are rather seriously involved, but if one of them is normal, or but slightly involved, the total function will be normal and the better kidney will show a function equal to its own proper function plus the deficiency created by the loss of function of the diseased kidney.

If ureteral catheterization is impossible, observation of the trigonal region, after the injection of indigo carmine, is the method of choice. Since cases of this type are usually late ones, the amount of dye coming from one side will usually be greatly in excess of that coming from the other side. One is thus able to determine which side is the more diseased and, if the total phthalein test gives normal results, one may assume

that the opposite kidney is in a fairly healthy condition and proceed to surgical treatment.

When it is possible to catheterize the suspected kidney, then one should take a retrograde pyelogram using diodrast for the contrast medium. When it is impossible to introduce a catheter into the suspected kidney, then one should take an intravenous pyelogram. This should give valuable diagnostic data.

#### TREATMENT

The results of nephrectomy in cases of uncomplicated unilateral renal tuberculosis are so excellent that there is no question that surgery is the treatment of choice in such cases. Important matters to be determined are: (1) Is the opposite kidney involved and, if so, to what extent? (2) Are additional lesions present in the urogenital tract? This question is much more important in men than in women. (3) Are there active foci of tuberculosis elsewhere in the body?

To answer the first question, careful observers have been able to demonstrate pus or tubercle bacilli, or to obtain a positive guinea pig test with material from the apparently sound kidney, and in many cases nephrectomy, carried out in spite of these results, has been entirely successful. It would appear then that when the affected kidney is the site of a severe and advanced lesion and the function of the opposite kidney is normal, the presence of a little pus or a few bacilli, demonstrated only with difficulty, should probably not deprive the patient of the chance of clinical cure, which he will have as a result of nephrectomy.

The second question can be more definitely answered, requiring only a thorough examination of the patient as previously outlined. If, however, genital foci are discovered, efforts should be made to remove them surgically, as completely as possible, within a short time after nephrectomy. The kidneys should be examined by ureteral catheterization in every case of genital tuberculosis, and likewise the genital organs should be studied thoroughly in every case of renal tuberculosis.

The third question may be answered by a thorough physical examination of the patient, including a roentgen examination of the chest. Extensive active tuberculosis of the lungs may necessitate delay in the surgical treatment of the renal tuberculosis, or even may, in some cases, contraindicate it. The same is true of

tuberculosis of the spine, tuberculous peritonitis and other forms of the disease.

In the presence of active pulmonary tuberculosis, the decision to operate becomes a difficult one. Beer<sup>4</sup> concluded that nephrectomy should be deferred in the hope of obtaining improvement or arrest of the pulmonary lesion. If, however, there is no improvement, he favored operation, since the added drain of renal infection and bladder symptoms may hinder pulmonary recovery. When the operation is performed, spinal anesthesia is to be preferred. The operation should consist of lumbar extraperitoneal nephrectomy. It is important to avoid tearing the kidney, with resultant spilling of tuberculous pus into the wound, or squeezing the kidney in such a manner as to drive tuberculous material into the circulation. The ureter should be clamped, tied and divided with a cautery. Young and Davis<sup>5</sup> advised that, in addition, a small quantity of carbolic acid be injected in the lower end of the ureter with the aim of destroying the mucosa and producing fibrous healing. The consensus is not to perform complete ureterectomy, and in clean wounds to leave the end of the ureter in the depths of the wound. I usually ligate the ureter as far down as possible in order to get as much out as possible and thereby leave less of the diseased ureter in place. A rubber tube is placed in the lower angle of the wound. This drain should be shortened and gradually taken out at the end of a week. One should never use gauze drainage.

If there is a mixed infection, it is a good plan to place sulfathiazole powder in the wound, and sulfathiazole tablets should be given orally in doses of 2 Gm. a day. Sinus tracts should be treated by irrigating the wound with about a pint of Dakin's solution, or exposing it to ultraviolet ray or sunlight. One must not forget to bring up the resistance of the patient by giving him vitamins, especially vitamin D, and urging rest and outdoor life.

Recently, in treating 2 cases of tuberculous cystitis with a mixed infection in which persistent pyuria and frequency of urination were present, I tried the following procedure: After irrigating the bladder through a catheter with a solution of boric acid, I allowed complete drainage to take place and then gently insufflated sulfathiazole powder into the bladder. The pyuria cleared up after two treatments, the frequency of urination

subsided, and the patient felt improved. In my opinion the patient benefited in these cases by the injection of the oxygen into the bladder as well as by the injection of the sulfathiazole, which definitely decreased the pyogenic cocci and had a beneficial action on the tuberculous lesions of the bladder. I plan to make further observations regarding this form of treatment as time and opportunity permit.

#### SUMMARY OF CASES

The following is a summary of 10 cases which have come under my personal observation at Harlem Hospital and in private practice:

Three cases occurred in women and 7 in men. The ages of the patients ranged between 20 and 40 years. The most common symptoms in all the 10 cases were frequency of urination, dysuria, and urgency. The next most common symptoms were hematuria and pyuria.

In all of these cases the patient made an uneventful recovery after nephrectomy. In 8 cases there was difficulty in healing the wound because the sinus tracts that formed. Before sulfathiazole and other sulfa drugs came into vogue, these sinuses persisted for some time. In the last year I have given the patient sulfathiazole internally in 2 Gm. doses per day and also used it locally in the tract, and I have observed that the sinus tracts heal much more quickly.

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## A NEW TYPE OF BARTONELLA INFECTION IN MAN?

#### PRELIMINARY REPORT

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The infectious splenomegalies, bacterial or protozoan, are constitutional diseases. Accurate diagnosis of any splenomegaly is difficult and requires the closest collaboration of the clinician, hematologist and pathologist.

This preliminary report presents a most interesting case of splenomegaly in which the positive diagnosis could not be proved. In view of the clinical course, hematologic studies and post-mortem findings, we feel justified in reporting this case as a splenohepatomegaly possibly caused by Bartonella infection. The causative agent is not considered to be Bartonella bacilliformis, the blood parasite causing Oroya fever (Carrion's disease), but rather a new type of Bartonella causing infection in man.

#### REPORT OF CASE

P. G. G., a white man aged 45, was admitted to the University Hospital, Coral Gables, on Feb. 25, 1942, complaining of weakness, progressive loss of weight, long standing fever, anemia, profuse sweats, nervousness, insomnia and progressive enlargement of the abdomen. The family history was irrelevant. The patient, a native of Missouri, moved to Miami at the age of 12, residing there until the time of admission. He had experienced no serious illnesses, except typhoid fever at the age of 14. He had made two short visits to Havana, Cuba, in 1918 and 1919, twenty-three years previously.

In April 1941 the onset of the illness was characterized by progressive loss of weight, fever, thirst, diaphoresis, pallor and insomnia. The patient declined medical attention until September, at which time he collapsed while at work. He was treated at home by Dr. John Shisler, who noted that he was greatly emaciated and was running a chronic, low grade fever with the temperature ranging from 99 to 101 F. An enlarged palpable spleen and anemia were also present. The blood pressure was 136 systolic and 80 diastolic. The abdomen was greatly enlarged with a visible palpable tumor in the left half.

On September 22 the hemoglobin estimation was 45 per cent, the red blood cell count was 3,150,000, the white blood cell count was 3,850 and the color index was 0.7. The differential count was lymphocytes 32 per cent, monocytes 7 per cent, eosinophils 1 per cent, neutrophils 60 per cent, stabs 4 per cent, segmented forms 56 per cent; anisopoikilocytosis, achromia, polychromia and stippling were present, also 1 nucleated red cell. No evidence of malaria was observed. All serologic tests for syphilis gave negative results. On September 27 all agglutination tests for typhoid and paratyphoid, A and B, and for typhus and undulant fever were reported to be negative.

**CLINICAL COURSE PRIOR TO ADMISSION:** The patient was treated at home for a period of five months before admission to the hospital. Treatment consisted of the administration of iron, liver extract and repeated whole blood transfusions. During the month of October he received sulfathiazole, during which period he remained afebrile. His appetite was good throughout this entire period, but loss of weight was progressive, for there was a reduction from 208 pounds in April 1941 to 140 pounds on Feb. 25, 1942, a loss of 68 pounds. A total of ten blood transfusions (500 cc. each) was given during the five months' period without any sustained improvement of the blood picture resulting. Blood studies at monthly intervals during this period showed a persistently severe anemia, with occasional reports of stippled red cells. The hemoglobin estimation ranged between 38 and 64 per cent, the red blood cell count between 2,150,000 and 3,470,000, and the white blood cell count between 2,900 and 3,850; the color index varied from 0.7 to 1.0 plus; the differential counts showed neutrophils 41 to 62 per cent, stabs 2 to 5 per cent, segmented forms 30 to 57 per cent, lymphocytes 32 to 59 per cent. On Nov. 18, 1941, myelocytes 2 per cent were reported.

**EXAMINATION ON ADMISSION:** When the patient was admitted to the hospital, the temperature was 98 F., the pulse rate 100, and the respiratory rate 22. The blood pressure was 134 systolic and 80 diastolic. He was pale, extremely emaciated and mentally alert, but highly apprehensive and nervous, with twitchings of the face. All reflexes were present and normal, but hyperactive. Physical findings of the body systems were negative, except that the abdomen was greatly distended with obvious splenic enlargement and visible splenic notch. The margin of the spleen extended to the midline, and the inferior border could not be felt below the left supriliac crest. The right lobe of the liver was palpable 1½ inches below the right costal border. The left lobe of the liver could be palpated on inspiration in the epigastrum. The report of the examination of the blood was hemoglobin estimation 40 per cent, color index 0.9, red blood cell count 2,150,000, white blood cell count, 3,350, and platelet count 38,000; the differential count was juvenile cells 4 per cent, segmented forms 37 per cent, lymphocytes 59 per cent, total neutrophils 41 per cent; clotting time, eight minutes; and bleeding time, three minutes. Urinalysis showed color, straw, specific gravity 1.002, hydrogen ion concentration 5.5, albumin 1 plus and sugar, negative. Microscopic examination of the sediment revealed 1 to 3 pus cells per high power field and 1 granular cast per low power field.

**PREOPERATIVE CLINICAL COURSE IN HOSPITAL:** The patient received whole blood transfusions, 500 cc. daily, between Feb. 26 and March 2. The temperature varied between 97 and 100 F. during this period. The red blood cell count improved 500,000; the white cell count remained between 3,500 and 4,200. The hemoglobin estimation increased 20 per cent, and the color index was raised from 0.9 to 1 plus. All blood smears showed stippled cells and a moderate amount of "peculiar inclusion bodies within the erythrocytes." An increase of juvenile forms, up to 8 per cent, was noted preoperatively. The platelet count was increased from 38,000 to 86,000 after five transfusions (500 cc. each). Bleeding time remained ten minutes, and clotting time two minutes, forty-five seconds. As a result of failure to improve the blood and platelet count, splenectomy was decided upon.

**DIAGNOSTIC IMPRESSION:** Infectious splenohepatomegaly.

**OPERATION:** Under cyclopropane anesthesia, a left rectus incision was made, and the abdomen was entered with the usual precautions. On entering the celomic cavity, a very large, tense spleen presented with well rounded margins and prominent splenic notch. The spleen extended to the midline and into the pelvic cavity. Its capsule was smooth, glistening and conspicuously free of adhesions, and showed many small (3 mm.) greyish white spots. The liver was greatly enlarged in both lobes, but did not appear cirrhotic. Pallor and absence of mesenteric fat characterized the appearance of the gastrointestinal tract. The retroperitoneal glands were enlarged and palpable in the upper part of the abdomen. An attempt to displace the spleen medially by inward rotation was unsuccessful because of posterior perisplenic adhesions between the capsule and the diaphragm. The gastrocolic ligament was opened, and an attempt was made to ligate the splenic artery and to autotransfuse. This proved unsuccessful, owing to the presence of five accessory spleens threaded along the lienal artery across the anterior border of the pancreas. The accessory spleens varied from 1 cm. to 4 cm. in diameter, extending from the celiac axis to the splenic notch. The dilated splenic vein was divided between clamps and doubly ligated, permitting of approach to the splenic notch, exposure of which afforded a small splenic artery between the distal two accessory spleens and proximal three accessory spleens. This portion of the splenic artery was doubly clamped and ligated with No. 2 silk ligature. The removed spleen, after venous drainage, weighed 3,500 Gm. After hemostasis, routine closure was carried out.

**POSTOPERATIVE COURSE:** The patient reacted promptly, evidenced mild shock and was given 500 cc. of blood plasma, followed with 500 cc. of whole blood. The condition improved greatly, and transfusions of whole blood, 500 cc. were given daily for the first three postoperative days. The blood pressure promptly returned to normal and remained so until death on the sixth postoperative day. The temperature rose to 100.8 F., dropped to 100 F. on the second postoperative day and returned to normal on the third postoperative day; it then rose to 100.2 F. on the fourth postoperative day and returned to normal the same day, again rising to 101 F. on the fifth day and continuing at this level until the sixth postoperative day, when it reached its greatest maximum of 101.2 F.

The patient remained mentally clear from the time of the reaction and stated he felt well until the third postoperative day, when he became semicomatose, sleeping at long intervals and awakening with lucid intervals, during which he stated he felt fine and expressed much gratitude for what had been done for him. Preoperative muscular twitching of the facial muscles and extremities continued and increased in severity during the entire postoperative period. It occurred both while he was awake and asleep, and attempts to control it with intravenous injections of calcium and parathyroid extract were only partially successful. The periods of coma increased and deepened gradually, until complete coma intervened about eight hours before death, associated with generalized convulsions. Nine blood studies showed no great improvement of the blood picture, despite the daily transfusions, and were characterized by a considerable increase of the "inclusion bodies" within the erythrocytes. The differential count on March 6, the fifth postoperative day, showed polymorphonuclear neutrophil leukocytes 61 per cent, myelocytes 2 per cent, monocytes 3 per cent, lymphocytes 32 per cent, young lymphocytes 2 per cent, and orthochromatic erythroblasts

2: basophilic stippling and polychromasia were present. Very slight anisocytosis and poikilocytosis were noted. Atypical platelets, larger and scanty, were observed. The leukocytes showed toxic changes in the granulations. The diagnosis was normochromatic normocytic anemia.

**DESCRIPTION OF "INCLUSION BODIES":** The hematologic studies revealed a few erythrocytes containing typical stippling. The stipplings thus noted were blue and measured from 0.1 to  $0.15\mu$ ; when large, they assumed a deeper purple color. In those cells which showed characteristic blue stippling, no other bodies were encountered, and stipplings were uniformly distributed within the cell.

In other erythrocytes, three distinct types of bodies were observed, namely, rings, rods and dots. These were encountered singly and collectively in different erythrocytes. All types were readily stained with Wright's and Giemsa's stains and were gram-negative. The ring forms were rare and morphologically resembled closely the ring bodies of estivoautumnal malaria. They measured from 1 to  $1.5\mu$ . They stained a pale blue, with one or two red dots diametrically opposed.

The rod forms were more plentiful, numerous erythrocytes showing from one to four rods. These rods were pleomorphic and presented two different staining characteristics. One group stained homogeneously a reddish purple and comprised many shapes such as straight, bowed, beaded, club and drumstick. Some straight rods in this group were arranged to form V, Y and arrow-shaped bodies. These rods measured from 1.5 to  $3\mu$  in length and  $0.2\mu$  in thickness. The other group stained a pale blue with one or two brilliant red dots situated at the ends. This group was uniformly larger, measuring from 3 to  $4\mu$  in length and from 0.3 to  $0.5\mu$  in thickness. The red dots at the ends of the rods measured  $0.15\mu$  in diameter.

The dot forms were more frequently encountered than the rods and rings. They were purplish red in color and measured from 0.2 to  $0.5\mu$ .

All the bodies described were arranged peripherally, conveying the impression that they were attached to the erythrocytes, or were lying immediately within the cell at the periphery (figs 1, 2, 3, and 4). All of these bodies were increased approximately four times in the smears made after splenectomy, when compared with those made before splenectomy.

**CULTURES AND INOCULATIONS:** Whole sterile blood was repeatedly taken from the patient for culture on Loeffler's and Noguchi's leptospiral mediums and on the developing chick embryo of Jiminez and Buddingh.<sup>1</sup> All results were negative in our hands.

On March 5, the day before the patient's death, citrated sterile blood was sent by air mail to the School of Tropical Medicine, San Juan, Porto Rico. Unfortunately, a delay of two days intervened before delivery.

Dr. Enrique Koppisch\* carried out the following cultures and animal inoculations:

2. Seeding in infusion and blood broth, 10 per cent, blood agar, Sabouraud's, and Noguchi's medium with agar.
3. Inoculation of a 16-month old rhesus monkey in the eyebrows (0.1 cc.) and intravenously (2.5 cc.).
4. Inoculation of mice (intracerebrally and intraperitoneally), guinea-pigs (intravenously) and rabbits (intracerebrally and intravenously).

The original blood had not been contaminated by bacteria, but it was warm when it reached us.

All animals, tissues and smears have been entirely negative. Some of the last subpassages have not yet been sacrificed for what I would consider the final study, but I wish to report on what I have done and on my failure to obtain any positive evidence in view of our last cable received yesterday. The remaining animals will be sacrificed in the course of this week and the next, but it seems now fairly certain that they will yield no additional information.

\*We wish to express great gratitude to Dr. Koppisch for his generous collaboration in this case.

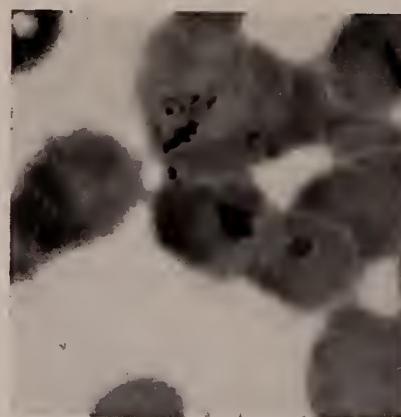


Fig. 1. One typical ring with red dot and several pleomorphic rods are shown.

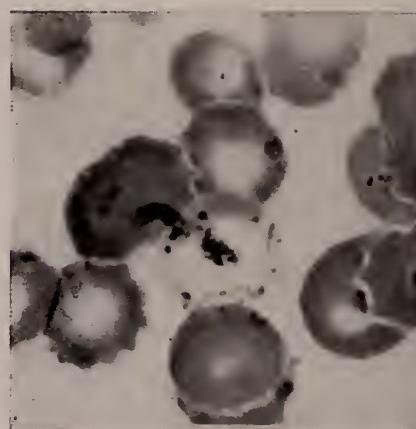


Fig. 2. Pleomorphic dots and rods peripherally arranged. One long rod (bottom of cell) had a pale blue body with brilliant red dots at ends. Rod at upper segment presents club shape.

#### PATHOLOGIC REPORT ON SURGICALLY REMOVED SPLEEN:

**Gross Findings:** The spleen weighed 3,500 Gm. and measured approximately 34 by 20 by 6 cm. It was soft in consistency, and the capsule was smooth and tense. The cut surface, bright red in color, showed, in addition to enlarged follicles, numerous greyish white nodules from 1 to 3 mm. in size, scattered throughout the entire organ.

**Histologic Findings:** Pronounced hyperplasia was observed throughout. There was also evidence of erythrophagia and hemosiderosis (multiple transfusions?).

The greyish nodules grossly described represented areas of necrosis with peripheral incrustations of iron surrounded by leukocytes. The cells of the reticuloendothelial system were increased in size and number. A few were loaded with dots and rods similar to those noted in the erythrocytes of the blood stream. They were not stained, however, by Giemsa's stain and therefore cannot be considered identical with the bodies observed in the red blood corpuscles. These rods and dots failed to give the iron reaction and remained brownish black in color. The reticulum fibers were increased. There was no evidence of Hodgkin's disease, nor of any type of leukemic process.

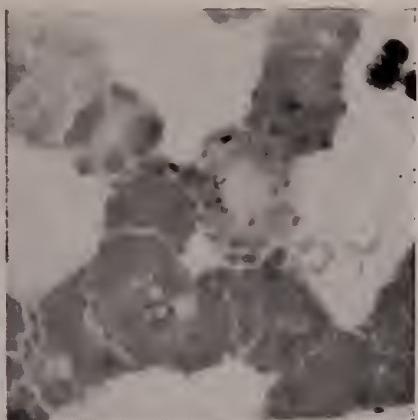


Fig. 3. In the central erythrocyte are shown numerous dots and one distinct V arrangement of rods.

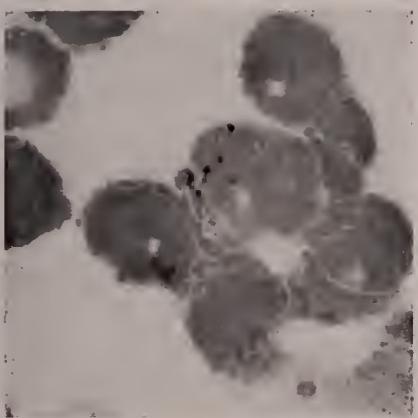


Fig. 4. In the central erythrocyte are shown several coccoid dots and one typical arrow formation of rods.

**PATHOLOGIC ABSTRACT:** Unfortunately, permit for an autopsy was granted only for the abdomen. External examination revealed extreme emaciation, pallor and enlarged axillary and inguinal glands. The abdomen was entered through the surgical wound. No evidence of postoperative hemorrhage or peritonitis was encountered.

**GROSS FINDINGS:** Liver: The liver was enlarged and weighed 2,500 Gm. Its surface was smooth and glistening. In consistency it was partly soft and partly doughy, and the cut surface was yellowish brown. In structure it was well preserved in some regions and very indistinct in others. In the preserved areas the lobules were separated by greyish white strands, and the periportal fields were well distinguished. The unpreserved portions consisted of small and large areas of necrosis, associated with hemorrhages in some instances.

Lymph Glands: Most of the retroperitoneal and mesenteric lymph glands were greatly enlarged. They were well encapsulated and of soft consistency. Their cut surfaces were greyish white and medullary in appearance. The omental lymph glands were moderately enlarged, with similar gross appearance.

Kidneys: The kidneys showed all signs of a great degree of parenchymatous degeneration.

Bone Marrow: The bone marrow of the femur was pinkish grey in color and of semifirm consistency.

**MICROSCOPIC EXAMINATION:** Liver: In sections of the liver from preserved areas the lobules were intact. There was no evidence of pseudolobules (cirrhosis). The periportal fields showed an increase of connective tissue, associated with edema and moderate chronic inflammatory reaction.

The Desse spaces were distended and filled with albuminoid debris. Both the Kupffer cells and the liver cells were loaded with iron pigment, but in less degree than the spleen (transfusions?). An occasional Kupffer cell contained suspicious rods and dots. Hematopoiesis, myelopoiesis and signs of Hodgkin's disease were nowhere observed.

The necrotic areas showed complete breakdown of the tissue of the liver, and small islets alone remained of severely damaged and unaltered tissue. In lobules with beginning necrosis, the process started around the central vein, or in the intermediate zone. In lobules with complete necrosis, only remnants of the connective tissue framework suggested the previous architecture. Some necrotic areas were surrounded by hemorrhage. The Kupffer cells, when present in the necrotic areas, contained a moderate amount of iron.

**Lymph Glands:** Inflammatory hyperplasia with enlarged and increased reticuloendothelial cells was pronounced. Iron deposit and erythrophagia were present, but to much less degree than was noted in the spleen. A few rod and dot formations were found in the endothelial cells. These did not stain positively with Giemsa stain and did not give the iron reaction; they remained brownish black in color.

**Kidneys:** Advanced hydropic swelling of epithelial cells with calcification of single cells of the tubular apparatus (sulfonamides?) was observed in the kidneys.

**Bone Marrow:** Areas of necrosis, hemorrhages, islets of connective tissue and active bone marrow were present. The active bone marrow showed all stages of maturing white and red blood elements. The megakaryocytes showed severe damage and were greatly reduced in number.

Very few rods and dots were seen in the red blood corpuscles and the sinus endothelial cells. A moderate amount of iron pigment was present. No evidence of a leukemic process was observed.

## DISCUSSION

The hematologic and histologic studies in this case showed no evidence of constitutional blood diseases, or Hodgkin's disease. The "inclusion bodies" observed can be differentiated from Howell-Jolly bodies, seen often after splenectomy, by the following criteria: Howell-Jolly bodies occur singly, or multiply, within the same corpuscle and stain a dark red color. The Howell-Jolly bodies are larger in size than the "inclusion bodies."

These bodies can be differentiated from Cabot's rings by the absence of real loops, or segments of loops. They were straight, or grouped to form V and arrow formations. Morphologically, they were thicker and darker. The largest of the rods stained a pale blue color, with one or two bright red dots at the opposite ends.

This latter criterion would exclude them definitely from classification as Cabot's rings.

Lauda and Flaum<sup>2</sup> confirmed the occurrence of erythrocontes described by Schilling,<sup>3a, b, c</sup> but these authors discountenanced their parasitic nature. Schilling has never described red dots within his so-called erythrocontes, nor has he described a V or arrow-shaped arrangement of erythrocontes. This fact would serve in itself to differentiate these bodies from the debatable erythroconte structures described by him.

Having differentiated the "inclusion bodies" from nonparasitic intraglobular structures, we were led to believe in their parasitic nature. We concluded that they resemble most closely the Bartonella group. Strong and his collaborators<sup>4a, b, c</sup> and recently Fox<sup>5</sup> have definitely established *Bartonella bacilliformis* as the cause of Oroya fever (Carrión's disease), which is restricted to Peru and Bolivia. Edelmann<sup>6</sup> claimed to have seen formations within the erythrocytes in thrombocytopenic purpura, which he suspected were some type of *Bartonella*. Lauda,<sup>7a</sup> in his morphologic study of these formations, noted their resemblance to *Bartonella*, but was not convinced of their parasitic nature, since Edelmann<sup>6</sup> had failed to prove it by biologic methods.

A great number of *Bartonella* have been described in the Vertebrata (nonmammalian and mammalian). Their morphology and biologic characteristics have been recounted by Weinmann.<sup>8</sup> With the limited number of descriptions available to us for comparison, we concluded that the "inclusion bodies" in our case were most comparable to *Bartonella canis Kikuth*.<sup>9a, b</sup> The great similarity suggests the possibility of *B. canis Kikuth* being pathogenic for man.

We hoped to establish the identity of these bodies, but failed to do so; nevertheless, we believe that further studies may prove that *B. canis Kikuth*, or other forms of *Bartonella* so far described in animals only, may prove to be pathogenic in man. This view is supported in some degree by the histologic findings. They bore great resemblance to the histologic findings, reported by Strong and his collaborators,<sup>4a, b, c</sup> in Oroya fever, and to those described by Mayer<sup>10a, b</sup> and Lauda<sup>7b</sup> in pernicious anemia of rats infected with *Bartonella muris*.

In the preoperative clinical course of the disease, during the month of October 1941 when sulfathiazole was administered to the patient, he remained afebrile. This fact further supports

belief in the infectious nature of the disease in our case. It does not seem reasonable that an infection caused by a parasite as widely distributed as the *Bartonella* group should, in the human, be geographically confined to one small area in South America.

#### SUMMARY

A case of splenohepatomegaly is presented in which a positive diagnosis was not proved.

The persistent severe anemia, associated with constant fever for a period of ten months and coupled with the hematologic and pathologic studies described, indicates a chronic infectious process.

The photomicrographs show clearly bodies which morphologically resemble closely some type of *Bartonella*.

A great increase of these bodies occurred after splenectomy in our case.

In animals, infected with *Bartonella*, splenectomy is followed by an increase of parasites in the erythrocytes.

It is hoped that in every splenomegaly, careful hematologic studies will be made of the so-called stippled red cells before and after splenectomy.

The findings in this case lead us to the hypothesis that *Bartonella* infection, other than *B. bacilliformis*, may be pathogenic for man.

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## SURGICAL CONDITIONS ASSOCIATED WITH ACUTE EPIDEMIC HEPATITIS

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The staff of the surgical service of an Army Station Hospital has had opportunity to make limited observation of the cases of acute epidemic hepatitis on the surgical wards. The epidemic, which made its appearance at this camp early in May of 1942, is rapidly disappearing during the last days of August. Present statistics reveal that 4,157 patients with acute hepatitis were admitted, and 70 of them appeared on the surgical service during their hospitalization.

The cause of this epidemic of acute hepatitis is not known except that all of the patients had received yellow fever vaccination in February or March of 1942. The disease was usually mild, but occasionally it reached the other extreme resulting in death. It was noted that the condition could be subclinical, or might vary in its manifestations from those of a mild icterus to those observed in the deeply jaundiced soldier in coma approaching death. A detailed study of acute epidemic hepatitis as a disease was made in this hospital by special representatives from the Surgeon General's Office.

Special interest was created at the onset of the epidemic regarding the way in which the patient with hepatitis would stand operative procedures. The results of operation in all cases of hepatitis presenting correctible surgical conditions would have been of great interest, but for the best interest of the patient these surgical measures were not thought advisable. Because of this conservative viewpoint only 8 patients were subjected to surgical procedures while they were in the acute stage of the disease (table 1, group 1). In all of these cases with one exception the patient had an uneventful convalescence. In one case an open reduction and internal fixation of the distal portion of the right radius occurred, and at the present time, eleven weeks postoperatively, there is no evidence of union at the site of the fracture. The operation was not complicated by infection, and it cannot be concluded whether or not hepatitis had any effect on the end results.

In 3 cases in which the patient was jaundiced (table 1, cases 2, 4 and 5), diagnosis of appendicitis was made and was confirmed in all at operation. In case 2 the tissues were highly icteric

throughout, and free bile-colored fluid was present in the abdominal cavity. Since the operation was performed through a McBurney incision, the gross condition of the liver was not observed. None of the tissue studied microscopically varied from that characteristic of the usual diseased appendix. In all of the cases of appendicitis the patient made an uneventful recovery.

In 7 cases, not included in the tables, in which the patient was hospitalized with a tentative diagnosis of appendicitis, further study revealed the condition was uncomplicated hepatitis. Ordinarily, there probably would have been more such cases, but the entire personnel of the camp became "liver conscious" following the onset of the epidemic. In almost all of the cases in which the patient was jaundiced there occurred some nausea and vomiting with accompanying abdominal discomfort and tenderness usually involving the middle and upper portions of the abdomen on the right side. As the liver enlarged, the distress extended lower in the abdomen on this side.

Group 2, indicated in table 1, is comprised of patients whose treatment for hepatitis was completed on the medical service and who were then transferred to the surgical service for operative care. All of these patients had an icterus index of 15 or below and were free of symptoms of hepatic disturbance upon transfer. In case 9, the first of this group, excision of the internal semilunar cartilage of the right knee was followed by a rupture of the joint capsule, resulting in a postoperative hernia. The complication started on the fifth postoperative day as a slight separation of the middle portion of the wound, and nine days later a well developed herniation was apparent. This defect was subsequently corrected surgically, and the patient is now making satisfactory progress. The cause of the breakdown of this wound is not known. The patient had been observed on the medical service for seventeen days before being transferred to the surgical ward twelve days prior to operation. His icterus index at its highest had been only 26.4 on the fifth day of hospitalization. No infection was detected in the postoperative wound to explain the defect.

Group 3, shown in table 1, includes those patients who had an operation and were convalescent when the hepatitis appeared. In none of these cases was there any variation from the normal course of recovery expected in similar surgical cases uncomplicated by jaundice.

There was no postoperative bleeding of wounds in the entire series of surgical cases in

TABLE 2.—NONOPERATIVE CASES

No.	Group	Hospital Admision Date	Admission to Surgical Service	Complicating Surgical Condition	Hepatitis Onset	Total Hepatitis Period (Days)	Highest Recorded Icterus Index	Period of Therapy with Drug	Total Hospital Days	Total* Hospital Days	End Results
36	V	5-11-42	5-11-42	Acute gonorrhea	6-8-42	25	20	7-3-42	Sulfathiazole—45 Gm. Sulapyridine—28 Gm. Sulfadiazine—9 Gm.	5-13-42 to 5-24-42 6-1-42 to 6-4-42 6-27-42 to 6-30-42	53 Good
37	V	5-25-42	6-5-42	Primary syphilitic tongue lesion	5-18-42	30	37.5	5-25-42	Sulfathiazole—60 Gm.	5-25-42 to 6-10-42	25 Good
38	V	5-25-42	5-25-42	Acute gonorrhea	6-1-42	30	60	6-4-42	Sulfathiazole—60 Gm.	5-25-42 to 6-10-42	37 Good
39	V	5-31-42	6-18-42	Acute sinusitis	5-29-42	27	40	6-8-42	Sulfathiazole—60 Gm.	5-25-42 to 6-10-42	26 Good
40	V	6-2-42	6-22-42	Acute tonsillitis	6-1-42	23	42	6-7-42	Sulfathiazole—108.6 Gm.	6-14-42 to 7-20-42	22 Good
41	V	6-8-42	6-11-42	Acute gonorrhea	6-4-42	10	22	6-9-42	Sulfathiazole—28 Gm. Sulfadiazine—28 Gm.	6-14-42 to 7-20-42 7-22-42 to 7-28-42	64 Good
42	V	6-10-42	6-10-42	Acute cellulitis of hand	6-11-42	6	20	6-12-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	7 Good
43	V	6-23-42	6-30-42	Acute balanopostitis	6-23-42	11	25	6-29-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	11 Good
44	V	7-13-42	7-15-42	Acute cellulitis of cheek	7-8-42	30	18	7-27-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	25 Good
45	V	8-1-42	8-1-42	Acute bilateral hordeolum	6-25-42	53	15	8-3-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	16 Good
46	VI	5-14-42	6-15-42	Epidermophytosis	5-7-42	45	37.5	5-7-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	60 Good
47	VI	5-26-42	5-26-42	Chronic prostatitis	6-7-42	23	11	7-3-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	39 Good
48	VI	6-2-42	6-2-42	Epidermophytosis	6-20-42	26	25	6-23-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	44 Good
49	VI	6-3-42	6-11-42	Chronic gonorrhea	6-2-42	25	15	6-4-42	Sulfathiazole—6 Gm.	6-21-42 to 6-22-42	24 Good
50	VI	6-12-42	7-9-42	Chronic pyelitis	5-29-42	40	45	6-13-42	Sulfathiazole—21 Gm.	7-15-42 to 7-22-42	45 Good
51	VI	6-16-42	7-8-42	Chronic prostatitis	6-10-42	31	50	6-20-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	25 Good
52	VI	7-11-42	7-11-42	Chronic prostatitis	7-10-42	6	12	7-15-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	5 Good
53	VII	5-11-42	5-29-42	Dislocated shoulder	5-7-42	22	16.1	5-12-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	62 Good
54	VII	5-14-42	5-14-42	Urethral stricture	5-17-42	14	30	5-19-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	17 Good
55	VII	5-15-42	5-15-42	Inguinal hernia	5-9-42	26	30	5-15-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	20 Good
56	VII	5-21-42	6-4-42	Hemorrhoids	5-11-42	58	40	5-21-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	60 Good
57	VII	6-6-42	6-6-42	Traumatic bursitis of knee	6-23-42	27	20	6-23-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	44 Good
58	VII	6-17-42	6-17-42	Sprained ankle	6-10-42	20	? <sup>?</sup>	6-23-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	13 Good
59	VII	6-19-42	6-19-42	Muscle tear, right hip	6-21-42	**	50	7-27-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	** Good
60	VII	6-24-42	7-8-42	Inguinal hernia	6-14-42	24	? <sup>?</sup>	7-27-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	14 Good
61	VII	6-26-42	6-26-42	Hemorrhoids	6-4-42	43	37	7-4-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	21 Good
62	VII	6-27-42	6-27-42	Tear, internal semilunar cartilage	7-4-42	23	40	7-7-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	34 Good
63	VII	7-31-42	7-31-42	Hemorrhoids	8-5-42	0	12	8-6-42	Sulfathiazole—25 Gm.	6-9-42 to 6-13-42	15 Good

\*Soldiers are usually hospitalized until physically able to do full duty.

\*\*Patients are in the hospital at the present time.

Group V—Nonoperative patients having acute infectious processes in addition to hepatitis.

Group VI—Nonoperative patients having chronic infectious processes in addition to hepatitis.

Group VII—Nonoperative patients having noninfectious processes in addition to hepatitis.

Average duration of hepatitis was 26.1 days.

Average highest recorded icterus index was 28.2.

TABLE I.—OPERATIVE CASES (ALL FRACTURES INCLUDED)

No.	Group	Hospital Admission Date	Admission to Surgical Service	Complicating Surgical Condition	Opera-tion Date	Operation	Anesthetic	Duration of Hepatitis at Operation (Days)	Icterus Index at Operation	Highest Recorded Icterus Index	Date Highest Recorded Icterus Index	Hepatitis Onset	Total Hepatitis Period (Days)	Post-operative Day Hepatitis Appeared	Total Hepatitis Days	End Results
1	I	5-19-42	7-17-42	Phimosis and venereal warts	7-17-42	Circumcision	Local	65	15	50	6-20-42	5-13-42	75		78	Good
2	I	5-24-42	6-10-42	Appendicitis	6-10-42	Appendectomy	Spinal	30	50	75	6-8-42	5-20-42	55		50	Good
3	I	6-8-42	6-8-42	Fracture, right distal radius	6-11-42	Open reduction & internal fixation	Brachial plexus block	21	20	20	6-11-42	5-18-42	36		22	Nonunion
4	I	6-14-42	6-14-42	Appendicitis	6-14-42	Appendectomy	Spinal	1	15	15	6-14-42	6-13-42	6		23	Good
5	I	6-15-42	6-15-42	Appendicitis	6-15-42	Appendectomy	Spinal	11	16.6	16.6	6-15-42	6-4-42	26		17	Good
6	I	6-29-42	6-29-42	Chronic tonsillitis	6-29-42	Tonsillectomy	Local	5	?	21	7-2-42	6-24-42	14		9	Good
7	I	7-2-42	7-3-42	Deformed toenail	7-3-42	Excision of nail	Local	18	14	14	7-3-42	6-15-42	29		10	Good
8	I	8-10-42	8-19-42	Fracture, right 5th metacarpal	8-24-42	Open reduction & internal fixation	Intravenous	2	21	21	8-24-42	8-22-42	**		**	
9	II	5-12-42	5-12-42	Tear internal semilunar cartilage	6-15-42	Excision of cartilage	Spinal			24.4	5-17-42	5-16-42	28		**	**
10	II	6-11-42	6-21-42	Phimosis	6-23-42	Circumcision	Local		?	?	5-20-42	24			19	Good
11	II	6-16-42	7-1-42	Sebaceous cyst	7-8-42	Excision of cyst	Local		12	6-29-42	5-27-42	34		28	Good	
12	II	6-17-42	8-10-42	Inguinal hernia	8-12-42	Herniorrhaphy	Spinal		11	7-10-42	6-17-42	36		**	**	
13	II	6-30-42	7-31-42	Strabismus	8-17-42	Muscle correction	Local		43	7-3-42	6-25-42	35		**	Good	
14	I	7-1-42	7-8-42	Phimosis	7-8-42	Circumcision	Local		14	7-2-42	6-10-42	28		20	Good	
15	II	7-3-42	7-23-42	Pterygium	7-23-42	Excision of pterygium	Local		38	7-14-42	7-3-42	37		37	Good	
16	III	3-31-42	3-31-42	Simple fracture, distal right tibia & fibula	3-31-42	Open reduction & internal fixation	Spinal		20	6-4-42	6-4-42	43		65	123	Good
17	III	3-31-42	3-31-42	Pilonidal cyst	4-22-42	Excision of pilonidal cyst	Spinal		25	6-22-42	6-20-42	14		60	96	Good
18	III	5-1-42	5-1-42	Fractured clavicle with delayed union	5-18-42	Removal of excess callus and immobilization	Intravenous		15	7-11-42	6-16-42	27		20	74	Good
19	III	5-10-42	5-10-42	Pilonidal cyst	6-1-42	Incision & drainage	Spinal		30	6-12-42	6-11-42	15		10	38	Good
20	III	5-21-42	5-21-42	Bilateral inguinal hernia	6-11-42	Bilateral herniorrhaphy	Spinal		12	7-2-42	6-14-42	37		3	47	Good
21	III	5-23-42	5-23-42	Bilateral inguinal hernia	5-28-42	Bilateral herniorrhaphy	Spinal		25	6-10-42	6-9-42	34		12	51	Good
22	III	5-25-42	5-25-42	Incisional hernia	5-27-42	Herniorrhaphy	Spinal		53	7-2-42	6-26-42	20		30	52	Good
23	III	6-1-42	6-1-42	Hemorrhoids	6-12-42	Hemorrhoidectomy	Caudal & transsacral		50	6-17-42	6-16-42	14		4	29	Good
24	III	6-10-42	6-10-42	Phimosis	6-10-42	Circumcision	Local		35	6-20-42	6-15-42	17		5	22	Good
25	III	6-18-42	6-18-42	Pilonidal cyst	7-7-42	Excision of pilonidal cyst	Spinal		10	7-10-42	7-8-42	10		1	**	**
26	III	6-22-42	6-22-42	Appendicitis	6-27-42	Appendectomy	Spinal		20	7-2-42	6-30-42	10		3	26	Good
27	IV	3-18-42	3-18-42	Simple fractures, articular surfaces left femur & tibia	3-10-42	Skin traction	None		20	6-13-42	6-13-42	32		86	125	Good
28	IV	4-13-42	4-14-42	Simple fractures, left internal & external malleoli	4-14-42	Plaster cast	None		15	6-13-42	6-13-42	26		60	85	Good
29	IV	4-21-42	4-21-42	Simple fracture, left transverse processes 3rd and 4th lumbar vertebrae		None	None		58.6	5-11-42	5-8-42	18			36	Good
30	IV	4-27-42	4-27-42	Simple fracture, external malleolus of left fibula	4-30-42	Plaster cast	None		30	6-2-42	5-20-42	28		30	51	Good
31	IV	5-14-42	5-14-42	Simple fracture, left internal malleolus and distal left fibula	5-14-42	Plaster cast	None		22.5	6-4-42	6-4-42	6		20	60	Good
32	IV	5-17-42	5-17-42	Simple compression fracture, 1st and 2nd lumbar vertebrae	5-20-42	Plaster cast	None				6-5-42	Transferred to a General Hospital				
33	IV	5-27-42	5-27-42	Simple incomplete fracture, left ilium		None	None		30	6-6-42	6-6-42	30			37	Good
34	IV	6-1-42	6-1-42	Simple fracture, distal right tibia	6-1-42	Plaster cast	None		64	7-2-42	6-15-42	42		15	**	**
35	IV	6-12-42	6-12-42	Simple fracture, distal 3rd left radius	6-12-42	Plaster cast	Intravenous		50	6-26-42	6-18-42	50		8	56	Good

\*Soldiers are usually hospitalized until physically able to do full duty.

\*\*Patients are in the hospital at the present time.

Group I—Patients operated on with acute hepatitis present.

Group II—Patients operated on after completing treatment for hepatitis.

Group III—Patients operated on in whom hepatitis developed while they were recuperating following surgical procedures.

Group IV—Patients developing hepatitis while recuperating from fractures treated by closed methods.

Average duration of hepatitis was 28.3 days.

Average highest recorded icterus index was 29.1.

Average duration of hepatitis in the 7 cases in which absolute bed rest was maintained while the disease was present was 23.3 days.



which hepatitis was present, and no vitamin K was administered. Inhalation anesthesia was completely avoided, and in cases 8 and 35 the patient received intravenously sodium pentothal, .75 and 1.1 Gm. respectively, with no harmful results. In major operative procedures procaine injected spinally was most frequently used to produce anesthesia.

In group 4 of table 1 are represented soldiers with fractures reduced by closed methods in whom hepatitis developed during the period of convalescence. The fractures healed within the average time limits expected for similar fractures in cases in which jaundice was not present. The patient in case 34 is still under treatment, but progress has been satisfactory to the present time.

The group of nonoperative surgical cases in which hepatitis was present is shown in table 2. It is divided into those cases associated with infections and those without infections. The former are subdivided into acute cases, group 5, and chronic cases, group 6; the latter comprise group 7. Sulfanilamide derivatives were administered orally in 6 cases (36, 38, 41, 47, 49, 50) during the period of hospitalization with no detectable ill effects. These drugs were given largely in the periods preceding and following the period in which hepatitis was present. The patient in case 37 has received weekly intramuscular injections of .2 Gm. of bismuth subsalicylate for the past fifteen weeks with no undesirable results. The noninfected group for the most part is composed of those soldiers having elective operative surgical conditions complicating the jaundice. This group would have been larger if conservative surgical measures had not prevailed. Shortly after the epidemic started, it was decided that in cases of hepatitis or suspected hepatitis the patient would not be subjected to elective surgery.

In review, there were no surgical deaths in this series, and in all cases, with two possible exceptions, no detectable harmful effects were observed which could be attributed to the hepatitis. There were no postoperative hemorrhages, and in the limited number of cases in which sulfanilamide derivatives were used (6) no harmful effects were noted following their administration.

These results were probably obtained because in the average case of hepatitis the patient was only moderately ill and a conservative surgical regime was followed throughout the epidemic. The fact that the total period in which hepatitis was present in the surgical cases with absolute bed rest maintained averaged only 23.3 days as compared with 27.2 days for the entire series is of in-

terest, but probably of little statistical value due to the few cases (8) in this group.

#### SUMMARY

A report of 70 cases of acute epidemic hepatitis observed on the surgical service in an Army Hospital is presented.



#### MEDICAL LITERATURE

FRANK G. METZGER, M. D.  
TAMPA

When one surveys the vast field of medical literature with its textbooks and numerous journals, both general and special, to say nothing of the syndicated health columns, the lay articles and the voluminous tracts and brochures of the manufacturers of drugs, a feeling of helplessness pervades one's very soul. What to read and when to read it are questions that confront every physician, but he finds the answers not too simple. If he reads a sufficient number of textbooks and journals, he discovers that practically every curative measure or diagnostic procedure has its "fors" and "againsts."

The thoughtful physician realizes that careful medical authors with basic knowledge of the subjects of their choice write valuable articles, but he is also aware that others, lacking this requisite, likewise make their literary contributions on the same subjects, frequently presenting diametrically opposite views. There meets his eye an impressive report by one author of a curative procedure giving results that are 90 per cent satisfactory while another writer, perhaps more, perhaps less discerning, describes the benefits of this same procedure as negligible. Entirely too often this puzzling complication confronts him.

Whom to believe and how to keep abreast of the worthwhile current literature in view of this situation are problems that create real mental conflict. Something is wrong here. It would seem that a concerted and honest attempt to analyze and correct this anomaly should be made, but to right it would of course involve the facing of unpleasant facts.

Who should, therefore, write medical articles? Obviously, the possession of vocal cords does not make everyone a good singer. Likewise, the possession of a degree of Doctor of Medicine does not necessarily give to the physician the ability to write scientific papers. The possession of a well equipped laboratory, clinical facilities and a sufficient number of cases to enable an investigator to control and eliminate the various factors which might affect the condition in question, are

basic necessities. In addition, a scientific mind of a certain type, one that can separate facts from conclusions and read the results of tests accurately, unclouded by preconceived ideas of hoped for results, is also a prerequisite if experiments and observations are to be of real value and, in consequence, worth reporting.

Thomas Edison once said, "Perspiration, not inspiration, is the big factor in all experimental work." It is indeed true that a great deal of work, observation and time need to be added to the basic requirements mentioned.

To the serious reader of medical articles the lack of these basic necessities is often glaringly apparent; to the casual reader their absence may be obscured by the impressive words of a voluminous essay, words which too frequently form meaningless phrases. A recent article contained this astonishing dictum, "In the treatment of this disease it is necessary to have the patient avoid contracting upper respiratory infections." Such an asinine statement offers ample evidence that the author possesses none of the qualifications requisite for the presentation of a medical report. Why should such an article be accepted by an editorial board and allowed to get into print?

In another type of article the author confuses facts and conclusions in the original premise. The whole article becomes a hodgepodge of conclusions or deductions presented as facts. The reader has no alternative but to choose between throwing the article aside or blindly accepting the writer's opinion as an established fact.

Many specialists' societies require that an applicant become a medical author before he is eligible for membership. Is it not obvious that the benefits obtained by association with the members of such a group and acquaintance with their special literature and discussions of their specialty would enable a candidate to write articles much more worthwhile after he had been a member for several years? And how is the physician who reads these articles written before admission to judge the fitness and experience of the author who lacks these important broader qualifications?

Too many articles pertaining to the specialties are published in the journals of a general nature. The average physician would in some instances need to use several medical dictionaries and study twenty different textbooks, more or less, before he could ferret out the author's meaning.

The physician who reads medical literature hesitates to admit that many a worthwhile con-

tribution remains unread because the author yielded to the temptation of using descriptive words only vaguely familiar to the average reader. Simplicity of terms, when a fine point of distinction is not sacrificed by their use, not only invites the physician's attention but also enables him to obtain understanding and receive help from perusal of the article.

There is of course much in favor of the present method of publishing everyone's ideas and results. It makes possible the compilation of thousands of case reports, observations and results that otherwise would doubtless not be available in sufficient quantity and over a sufficient period of time.

If physicians will report their experiences, observations and experimental work with a full explanation of the related conditions and associated circumstances, an invaluable and irreplaceable contribution will be made to the advancement of medical science. If these authors will recognize and reject the temptation to make definite statements concerning controversial subjects from too little material or too little knowledge of other factors affecting the results they report, then the good will be retained and the objections will be removed.

Nor in papers by authors who are without the essentials mentioned need the expression of logical ideas be lacking. Many physicians make up for the lack of mechanized facilities by developing a keen sense of observation. It is to be remembered, too, that the apparent proof given by the test tube must stand or fall under the acid test of time and trial by the practitioner in the field.

Another seeming fault with medical literature is the tendency to report and overemphasize the unusual case or the rare disease. Certainly a report of this nature is important, but a small point in the understanding of a common ailment or a slightly better procedure in its treatment is often of more practical value. This all too common practice of overemphasis has a tendency to make the average reader conclude that these rare instances represent a much higher percentage of human ills than actual figures bear out.

It would appear that the present confusion arises largely from the manner in which authors present their reports. It is with the hope that the members of the Association will submit more and better papers for publication that this article is presented.

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## FLORIDA LEGISLATURE

Bills introduced at the 1943 session of the Florida Legislature relating to public health were of particular interest to the medical profession. A number of good bills became law, and a number, which in the opinion of physicians would have been detrimental to public health, were defeated. Dr. Harold D. Van Schaick of Jacksonville, chairman of the Association's Committee on Legislation and Public Policy, at a sacrifice to his own practice, devoted much of his time during the entire legislative session to the interest of the public. Officers of the State Association and of county medical societies, as well as a host of members, cooperated generously. Paradoxically, the physician's interest in the Legislature is to support bills which will keep our citizens well, rather than to foster those which might increase his personal practice.

There was statewide interest in House Bill 308, relating to the appointment of members of the State Board of Health. The original bill was amended to such an extent that its authors requested that it be killed. It did not become a law.

Senate Bill 641 became a law. It designates a time limit for the recording of medical licenses. Heretofore, the law required licenses to be recorded but set no time limit. This amendment to the Medical Practice Act should do much to prevent impostors from using fraudulent licenses.

Senate Bill 639, providing for aid in the enforcement of the Medical Practice Act, and Senate Bill 640, seeking appointment of an assistant to the secretary of the State Board of Medical Examiners, both died on the calendar. The secretary of the State Board of Medical Examiners

is always a busy physician and needs an assistant to testify in court regarding records of the Board.

House Bill 146, prohibiting the disclosure by any authorized physician or surgeon of any communication or information acquired by him in his professional character from any patient, without his consent, died on the calendar and, therefore, did not become a law..

Senate Bill 621, which would have forbidden public hospitals from refusing hospital privileges to any doctor licensed to practice medicine, failed to pass.

A number of new laws were put on the statute books to aid in the control of venereal diseases.

Those new laws which particularly concern the practice of medicine will be included in full in the 1944 issue of the Florida Medical Directory, a copy of which will be mailed to each member of the State Medical Association.

The following are enacting clauses or synopses of a number of new laws that were put on the statute books at the recent session of the Legislature:

**Physicians with armed forces to be kept in good standing by State Board of Medical Examiners—S. B. No. 264:** an act defining the term "Administrative Board of State of Florida;" providing that any member of the armed forces of the United States of America now or hereafter on active duty, who, at the time of his becoming such a member, was in good standing with any administrative board of the State of Florida, and was entitled to practice or engage in his profession or vocation in the State of Florida, shall be kept in good standing by such administrative board of the State of Florida, without registering, paying dues or fees or performing any other act on his part to be performed, as long as he is a member of the armed forces of the United States of America on active duty, and for a period of six months after his discharge from active duty as a member of the armed forces of the United States of America; repealing all laws and parts of laws, general and special, in conflict with this act; and providing when this act shall take effect.

**Licenses issued by State Board Medical Examiners must be recorded with clerk of circuit court within sixty days—S. B. No. 641:** an act relating to the practice of medicine, and to the recording of licenses to practice medicine, specifically amending section 458.06 of the Florida Statutes, 1941.

**Appropriation for insulin—H. B. No. 67:** an act to amend the provisions of section 381.65, Florida Statutes, 1941, relating to an appropriation for the purchase and distribution of insulin, by providing an annual appropriation of twenty thousand dollars for such purposes.

**University of South Florida—S. B. No. 306:** an act to create a State University to be known as the "University of South Florida," whose primary purpose shall be a school of medicine, a school of pharmacy and a school of dentistry.

**State Tuberculosis Sanatorium—H. B. No. 700:** an act amending section 392.10, Florida Statutes, 1941, relating to the admission of patients to the State Tuberculosis Sanatorium and providing for the payment of the care and maintenance charges of such patients therein.

**Subsequent reports on venereal disease cases—S. B. No. 139:** an act to amend section 334.06, Florida Statutes, 1941, relating to reports of venereal disease cases to the State Board of Health, by requiring subsequent reports concerning treatment and care.

**Venereal disease reports used to enforce compulsory treatment laws—S. B. No. 140:** an act to amend section 384.10, Florida Statutes, 1941, relating to reports of venereal disease cases to State Board of Health, by providing that such reports shall be used by State Board of Health in enforcing compulsory treatment laws.

**Persons rejected or deferred for military service, infected with venereal disease, must report to venereal disease clinic—S. B. No. 141:** an act requiring all persons rejected or deferred for military service, who are infected with venereal disease, to report to venereal disease clinics operated by the State Board of Health and take treatment from private physicians or at public expense, prescribing prima facie evidence of such infection, and providing penalties for violations of this act.

**Revocation of hotel or apartment house licenses for violation of law against prostitution—S. B. No. 142:** an act to amend section 511.05, Florida Statutes, 1941, relating to revocation of licenses of hotels, apartment houses, rooming houses and restaurants, by adding as an additional ground for such revocation, any violation of the law against prostitution, lewdness or assignation.

**Prohibiting lewdness, assignation and prostitution—H. B. No. 238:** an act defining and prohibiting lewdness, assignation and prostitution, making it unlawful to engage in, solicit, procure for, aid or abet, lewdness, assignation, or prostitution, providing for the admission in evidence of certain testimony in trials hereunder, and providing penalties for the violation of the provisions of this act.

**Prohibiting compulsory prostitution—S. B. No. 144:** an act prohibiting compulsory prostitution, prescribing penalties for violations of this act, and repealing all laws in conflict herewith.

**Unlawful to live off earnings of a prostitute—S. B. No. 145:** an act making it unlawful to live off the earnings of a prostitute, providing penalties for violation of this act, and repealing all laws in conflict herewith.

**Unlawful to rent any place for purpose of prostitution—S. B. No. 238—H. B. No. 237:** an act making it unlawful to let or rent any place for the purpose of prostitution, lewdness or assignation, prescribing penalties for violations of this act, and repealing all laws in conflict therewith.

**Quarantine and treatment of persons infected with venereal disease—S. B. No. 616:** an act relating to quarantine and treatment of persons infected with venereal disease, authorizing health officers to quarantine such persons in hospitals operated for that purpose, requiring sheriffs and chiefs of police to deliver certain infected persons to health officers for quarantine and treatment, providing for the transportation of such infected persons to the place of quarantine, providing for payment of expense incident thereto, and repealing all laws in conflict herewith.

**State Hospital for care and treatment of persons afflicted with venereal disease—S. B. No. 5:** an act to establish at or near Avon Park, Florida, a State Hospital for the care and treatment of persons afflicted with venereal disease, and for the construction of the necessary buildings and equipment of such State Venereal Hospital, and to provide for the staffing, supervision, management and control of such institution, and making appropriation therefor.

**Amend Workmen's Compensation Law for increase in employer's liability—H. B. No. 372:** an act to amend section 440.12, Florida Statutes, 1941, and section 440.13, Florida Statutes, 1941, as amended by section 2, Chapter 20672, acts of 1941, relating to the Workmen's Compensation Law; by providing for an increase in the employer's liability for the weekly payments of compensation to injured employees and authorizing the Industrial Commission within a certain time to order the employer, and/or insurance carrier to furnish medical treatment to injured employees in excess of one thousand dollars if the nature of the injury or the process of recovery requires such action.

**County judges' courts to issue delayed birth certificates—H. B. No. 94:** an act authorizing the county judge's court to issue delayed birth certificates; providing for a cumulative method for obtaining delayed birth certificates upon petition and order in the county judge's court, authorizing the county judge's court to order and certify the date of birth, place of birth and parentage, or any of such facts of any resident of the State of Florida, providing for the filing of a copy of such certificates with the Bureau of Vital Statistics, State Board of Health, requiring said Bureau to furnish necessary blanks and authorizing certified copies thereof, providing the effect of such order, and for the appeals from the same.

**Aid to the blind—S. B. No. 172:** an act to amend section 409.17, Florida Statutes, 1941, as amended by section 1 of Chapter 20,714, laws of Florida, acts of 1941, relating to aid to the blind. There is a provision providing for monthly assistance of not more than \$40.00 to any blind person, under certain conditions.

**Hospitalization and sick benefit system, Miami Beach—H. B. No. 637:** authorizing the city council of Miami Beach to establish by ordinance a hospitalization and sick benefit system for any or all groups of officers and employees in the service of said city.

**Calhoun County tax levy for public health unit—H. B. No. 988:** authorizing Calhoun County to levy a tax for establishing a county public health unit.

**Optometry—H. B. No. 477:** an act to amend sections 463.01, 463.05, 463.08, 463.09, 463.10, 463.16, 463.17 and 463.18, Florida Statutes of 1941, relating to the practice of optometry.

**Defining trade of opticians—S. B. No. 366:** an act defining trade or occupation of opticians; providing for a license tax on persons, firms or corporations engaged in such trade or occupation; providing the persons, firms or corporations engaged in such trade or occupation shall not be subject to the jurisdiction of any board, agency or commission regulating any other trade, occupation or profession; repealing all laws or parts of laws in conflict herewith and providing for the effective date of this act.

**Amendment to naturopathic law—S. B. No. 41:** an act to amend sections 462.01, 462.08, Florida Statutes, 1941, defining naturopathy and relating to examination, license and registration requirements for the practice of naturopathy; providing additional requirements for granting renewal licenses; providing for restoration of expired licenses and registration with State Board of Health; recognizing provisions of Florida Basic Science Law; providing for partial invalidity of Chapter; and repealing all laws in conflict herewith.

**Creation of Board of Masseurs—S. B. No. 367:** an act to protect the health, safety and welfare of the people of the State of Florida; defining terms used in this act; prescribing regulations for the practice of massage and the conduct of massage establishments; providing for the creation of a board of masseurs and defining the powers and duties of such board; providing for the inspection of all massage establishments and schools and requiring the registration of all who practice or teach massage; appropriating the proceeds thereof to accomplish the purposes of this act; and providing penalties for the violation of any provisions of this act.



## MEDICAL POSTGRADUATE COURSE

The eleventh annual graduate short course for doctors of medicine, held in Jacksonville, June 21 through 26, drew a total attendance of 189, the second largest on record. The attendance last year was 195, which exceeded by more than 50 any previous attendance. This year's registration would be creditable in normal times, but considering that our nation is at war and more than 400 of our members are with the armed forces, it is outstanding.

Under the leadership of Dr. T. Z. Cason, chairman of the Association's Committee on Medical Postgraduate Course, with the cooperation of his committee members, the Department of Medicine of the Graduate School of the University of Florida and the State Board of Health, a splendid foundation has been laid during the past eleven years. The continued interest of all concerned and the results experienced the last few years attest to the success of this program. Outstanding medical specialists in the United States were on the faculty, many of whom are noted authorities.

The official report on this year's graduate short course will be presented at the next meeting of the House of Delegates of the Association by Dr. T. Z. Cason, chairman of the committee.

## REGISTRATION

The total registration during the eleventh annual graduate short course for doctors of medicine, held in Jacksonville, June 21 through 25, was 189. Of this number 123 paid the \$5.00 registration fee. Members numbered 97; members with the armed forces, 6; other physicians with the armed forces, 41; other physicians, 13; interns, 4; Negro physicians, 28. The following were present:

## FACULTY

**Medicine**—Robert W. Wilkins, Associate Professor of Medicine, Boston University.

**Surgery**—Alton Ochsner, Professor of Surgery, Tulane University of Louisiana, New Orleans.

**Pediatrics**—Samuel F. Ravenel, Dean of the Southern Pediatric Seminar, Saluda, N. C.

**Obstetrics**—M. Pierce Rucker, Obstetrician, Johnson-Willis Hospital; Visiting Obstetrician, Retreat for Sick; Sheltering Arms Hospital, Richmond, Va.

**Gynecology**—Clayton T. Beecham, Assistant Professor of Obstetrics and Gynecology, Temple University, Philadelphia.

Venereal Diseases—Austin V. Deibert, P. A. Surgeon, Medical Officer in Charge, Venereal Diseases Medical Center, United States Public Health Service, Hot Springs.

## COMMITTEE

T. Z. Cason, Chairman	Jacksonville
W. W. George, Member	West Palm Beach
Frank D. Gray, Member	Orlando
R. B. Harkness, Member	Lake City

## ASSISTANTS

O. E. Harrell, Projecting Lantern	Jacksonville
Stewart Thompson, D.P.H., Acting Registrar	Jacksonville

## PHYSICIANS BY CITIES

*Arcadia*: H. P. Bevis, John A. Simmons. *Baldwin*: W. D. Brinson. *Blanding*: E. J. Hern. *Bradenton*: M. M. Harrison, S. G. Hollingsworth. *Brooksville*: G. R. Creekmore. *Canal Point*: D. C. Thompson. *Chiefland*: W. C. Young. *Dunedin*: H. E. Winchester. *Eustis*: C. McK. Tyre, R. H. Williams. *Ft. Lauderdale*: Frank Denniston, R. L. Elliston, H. J. Peavy, Leigh F. Robinson, Jean Walker. *Ft. McCoy*: Percy F. Lisk. *Ft. Myers*: F. D. Bartleson. *Gainesville*: John E. Maines, Jr., H. M. Merchant, Walter E. Murphree, Thomas A. Snow, W. C. Thomas, George C. Tillman. *Havana*: J. W. Sapp.

*Jacksonville*: Matthew Arnow, Dean C. Austin, F. J. Auwers, Robert M. Baker, W. H. Brooks, H. Ivan Brown, Samuel R. Brown, H. A. Carithers, Jr., Joseph L. Chilli, H. W. Coleman, H. W. Counts, S. E. Driskell, Henry M. Dux, L. Y. Dyrenforth, J. V. Freeman, Lawrence E. Geeslin, Henry Hanson, Paul Hayes, Luther W. Holloway, Edward Jelks, Nathaniel Jones, Theodore C. Keller, Janet Leser, Louie Limbaugh, J. G. Lyerly, Robert B. McIver, Charles B. Mabry, Webster Merritt, George M. Mitchell, Kenneth A. Morris, Robert H. Nickau, S. R. Norris, George F. Oetjen, Harvey H. Pettry, Harry A. Peyton, Harper L. Proctor, Harold Rand, Ruth E. Ray, C. D. Rollins, William E. Ross, L. M. Sompayrac, L. V. Tyler, E. W. Veal, F. J. Waas, J. Warren, Charles E. West. *Jasper*: E. C. Crouch. *Key West*: J. B. Parramore. *Lake Butler*: John E. Maines, Sr. *Lake City*: H. S. Howell. *Lakeland*: J. R. Boulware, Jr. *Lake Wales*: R. E. Wilhoite. *McIntosh*: J. L. Strange. *Melbourne*: I. K. Hicks.

*Miami*: Herbert Eichert, R. M. Fleming, Elmo D. French, Laura M. Hobbs, William M. Howdon, Jack Humphreys, Walter C. Jones, George D. Lilly, James F. Lyons, H. E. Parnell, C. L. Perry. *Micanopy*: I. A. Dailey. *Mount Dora*: S. C. Colley. *New Smyrna Beach*: W. C. Chowning. *Ocala*: T. H. Davis, Bertrand F. Drake, R. D. Ferguson, Eugene G. Peek. *Orlando*: Clarence Bernstein, Spencer A. Folsom, Pleasant L. Moon. *Pahokee*: George W. Elarbee. *Pensacola*: D. E. Cline. *Pompano*: George S. McClellan. *Quincy*: Julius C. Davis. *St. Augustine*: Morris H. Miller. *St. Petersburg*: Arnold S. Anderson, Roscoe H. Knowlton, Leon Thursten, Claude B. Wright.

*Tallahassee*: George S. Palmer, J. H. Pound, B. M. Rhodes. *Tampa*: Elsie M. Gilbert. *Vero Beach*: P. T. McClellan. *West Palm Beach*: S. W. Fleming. *Winter Garden*: J. W. Clower. *Winter Haven*: Waldo Horton. *Winter Park*: Ruth S. Jewett.

*Alabama*—*Alexander City*: Samuel M. Day. *Colorado*—*Denver*: D. O. Lynn. *Georgia*—*Eastman*: Harold W. Long. *Folkston*: W. R. McCoy. *Kingsland*: R. Roy McCollum, Jr. *Illinois*—*Highland Park*: E. A. Rygh. *Indiana*—*Indianapolis*: Edwin R. Eaton, William S. Yocom. *Kentucky*—*Danville*: George McClure. *Louisiana*—*New Orleans*: Herman Rabinowitz, E. G. Walls. *Maryland*—*Baltimore*: Harry Weintraub. *Massachusetts*—*Boston*: Allan D. Callow. *Revere*: Cornelius J. Driscoll. *Mississippi*—*McComb*: Verner S. Holmes. *New Jersey*—*Newark*: Clement H. Golden. *Pompton Plains*: Leo L. Leueridge. *New York*—*Buffalo*: Robert B. Newell. *New York City*: Robert Rosenfeld. *North Dakota*—*Fargo*: Lynn C. Fredrikson. *Ohio*—*Brunswick*:

Robert E. Eyssen. *Cincinnati*: Carroll J. Fair, Lester A. Russin. *Sandusky*: James E. Ryan. *Pennsylvania*—*McAdoo*: Stephen E. Matsko. *Patton*: G. E. Dvorchok. *South Carolina*—*Greenville*: Joseph I. Converse. *Tennessee*—*Chattanooga*: James R. Fancher. *Memphis*: M. J. Tendler. *Virginia*—*Richmond*: Herman W. Farber. *West Virginia*—*Clarksburg*: Marcus E. Farrell.

## NEGRO PHYSICIANS

*Bartow*: L. W. McNeill. *Daytona Beach*: T. A. Adams, H. E. Bartley. *DeLand*: L. C. Starke. *Ft. Lauderdale*: R. L. Brown, Von D. Mizell, J. F. Sistrunk. *Ft. Myers*: E. E. Velasco. *Ft. Pierce*: C. C. Benton. *Gainesville*: Julius A. Parker. *Jacksonville*: S. Spearing Campbell, S. B. Daniel, C. Frederick Duncan, E. H. Flipper, R. F. Mills, J. P. Patterson, W. W. Schell, I. E. Williams. *Ocala*: N. H. Jones. *Sanford*: George H. Starke. *Tallahassee*: W. H. Baker, L. H. B. Foote. *Tampa*: J. C. Hodges, R. Reche Williams. *West Palm Beach*: J. H. Russell Dyett, T. R. Vickers. *District of Columbia*—*Washington*: Howard M. Payne. *Tennessee*: —*Nashville*: Neill O. Crosslin.



## PHYSICIANS SHOULD INFORM SELVES

## ABOUT NEW SOCIAL SECURITY BILL

Physicians should inform themselves concerning the origin and objectives of the proposed Wagner-Murray-Dingell bill for broadening the American social security program. The Journal of the American Medical Association for June 26 advises in an editorial discussing the measure. The Journal says:

In its evolution the . . . bill stems from the National Health Conference of 1937, the Wagner bill which followed that conference, and the report of the National Resources Planning Board. Essentially in its medical aspects it is a compulsory sickness insurance bill and an attempt to translate the proposals of the Social Security Board into a technic of action. Inquiry of reliable sources in Washington indicates the probability that the actual designers and authors of the bill included I. S. Falk, director of the Bureau of Research and Statistics of the Social Security Board of the Federal Security Administration, Mr. Wilbur J. Cohen, technical adviser to the Social Security Board, and Senator Wagner's secretary, Mr. Philip Levy. . . . Inquiry also reveals that, as far as can be determined, representatives of the medical profession, either within or without the government, were not consulted in the development of the medical provisions. Evidence of this failure to consult the medical profession appears in the language of the proposed bill, since it speaks twice of a "spell of sickness." The word "spell," thus employed, does not appear in English dictionaries except as a colloquialism in Webster, and the term is seldom, if ever, used by any one educated in medicine. . . .

Speaking bluntly . . . the measure apparently attempts to avoid the numerous difficulties involved in developing a government controlled medical service by making the Surgeon General of the Public Health Service, whoever he might be, a virtual "gauleiter" of American medicine. Indeed, it is doubtful if even Nazidom confers on its "gauleiter" Conti the powers which this measure would confer on the Surgeon General of the U. S. Public Health Service. . . .

In offering the bill, its proponents emphasize that it provides for free choice of doctors; free choice of a doctor means of course, free choice of doctors willing to engage in this type of work. . . .

## DO NOT PUBLISH UNCENSORED LETTERS

The following statement appears in The Journal of the American Medical Association for June 19:

A letter from the Office of Censorship in Washington requests the editor of the Journal to call the attention of editors of state medical journals and of the bulletins of county medical societies particularly and also editors of all other medical publications to the fact that it is exceedingly inadvisable to publish uncensored letters coming from doctors in the service, particularly when they include the addresses of the physicians. Already in several instances such letters have served to reveal the identity of troops overseas. The Code of Wartime Practices for the American Press calls attention to the great danger that is inherent in this practice.

All publications are particularly requested to avoid identification of soldiers with their troop units when they are overseas, about to embark or on defense (as distinguished from training) activities in the United States. In the case of Naval personnel the identification of ships and bases is to be especially avoided. Editors of all publications will, we are sure, do their utmost to cooperate with the Office of Censorship in Washington, since the revealing of units to which physicians are attached may be of great value to the enemy in determining the character of the armed force with which it has to deal. When in doubt, editors will do well to get a direct response from the Office of Censorship regarding the release of any special item.

## MARRIAGES AND DEATHS

### MARRIAGES

Dr. William M. Stinson and Mrs. Flora N. Doe of Jacksonville were married on June 23.

### DEATHS

Dr. Julian C. Chandler of Tampa died on May 20. Dr. Julian F. Gardner of Winter Park died on June 20. Dr. Burton T. Gordon of Pompano died on July 2.

## STATE NEWS ITEMS

The Miami Biltmore Hotel located at Coral Gables is now formally designated the "Army Air Forces Regional Station Hospital." It has 1,200 beds. Only ten floors of the skyscraper building are in use, although the hospital capacity can be expanded greatly. There is a staff of 41 doctors and 80 nurses on duty. The hospital was opened in mid March.



Examinations were held June 21 and 22 in Jacksonville by the State Board of Medical Examiners. Eighty-two doctors took the written examinations for licenses to practice medicine in Florida. Dr. W. M. Rowlett, secretary of the Board, will submit a list of those who are eligible for licenses, at a later date, and the complete list will be published in the Journal.



Dr. Bruce R. Tinkler of Lake Wales spent several weeks in Boston, attending a medical school during the month of June. Dr. Tinkler visited relatives in Virginia en route.



Dr. Julien C. Pate, Sr., of Tampa attended the International Assembly of the International College of Surgeons in New York during the month of June.

## CLIFTON PRICE BULLARD

Dr. Clifton P. Bullard, who practiced medicine and surgery in Miami for the past twenty years, died suddenly at his home on May 25.

Dr. Bullard was born in Hamilton County in 1887. After his premedical training, he attended the Georgia Eclectic College of Medicine and Surgery in Atlanta, from which he was graduated in 1910. He then took postgraduate work in Chicago, at the Mayo Clinic in Rochester, Minn., and at the Sewanee, Tennessee College.

He was a member of the Dade County Medical Society, the Florida Medical Association, and of the American Medical Association. He was also affiliated with the Modern Woodmen of the World and the Elks Club.

Surviving are his widow, Mrs. Emma Jessie Bullard; three daughters, Mrs. Cleo C. Smith of Augusta, Ga.; Norma Nelle of St. Louis, and Mrs. Lynn Paskewich of Miami; three brothers, Ferman of Dupont, Ga., Dewey and Clyde of Lake City, Fla.; and two sisters, Mrs. Mozelle Mershon and Etha Bullard of Lake City.

The Southern Medical Association will hold its annual meeting in Cincinnati, November 16, 17 and 18. The Executive Committee of the Council of the Association decided that war had not lessened the need for a meeting and that the three-day meeting in November will be equally divided between civilian and military medicine.

## JURIAH HARRIS PIERPONT

Dr. J. Harris Pierpont of Pensacola, oldest past president of the Florida Medical Association, died on May 23, 1943.

Born in Savannah, February 25, 1864, the son of James and Eliza Jane Purse Pierpont, he spent his boyhood in Quitman, Ga. At the age of 17 he became a telegrapher and for several years worked for railroads in Georgia and Florida in that capacity and as agent. During these years he began the study of medicine. Later he attended the Medical College of Richmond, Va., from which he was graduated in 1888. He served his internship in the Richmond City Almshouse Hospital.

On October 25, 1888, young Dr. Pierpont came to Pensacola; he practiced his profession in that capacity and as agent. During these years 1940. On October 21, 1894 he was married to Lucy P. Warren, daughter of Mr. and Mrs. A. F. Warren.

Dr. Pierpont was appointed an assistant surgeon for the Pensacola division of the L. & N. Railway in April, 1894, and held that position until in 1935 when he was appointed district surgeon. On his retirement from active practice, he was retained as consultant surgeon by the railroad.

Dr. Pierpont was one of the organizers of the Pensacola Medical Society, later known as the Escambia County Medical Society. In 1890, while serving as a delegate to the annual convention of the State Association, he was elected vice president, and later succeeded to the presidency upon the death of the president. Ten years later he was again elected president of the Association, and the following year was re-elected to that high office. He had the distinction of being the only physician to serve as president for more than one term within the last 66 years, for which records are available.

During his six years' service as city physician and health officer an epidemic of yellow fever oc-

curred in 1905. The State Board of Health assumed charge and the epidemic was stopped six weeks before the first frost. Besides his official duties at the time, Dr. Pierpont operated an emergency hospital and treated more than 80 patients.

As chairman of the Legislative Committee of the State Association, Dr. Pierpont was instrumental in creating the State Board of Medical Examiners. Among his other professional positions were: president of the Pensacola Medical Society and later of the county society; president of the surgical staff of Pensacola Hospital; relief port physician for several years; delegate from the State Association to the American Medical Association; member and president of the United States pension board of medical examiners; physician to the Woman's Home; instructor in obstetrics for the Pensacola Hospital Nurses' School; director of West Florida Receiving Home; life member of the American Medical Association and the Florida Medical Association; member of the Southern Medical Association.

Dr. Pierpont served for many years as vice consul for Argentina. He was surgeon for saw mills and manufacturing plants for a long period. He traveled abroad twice and visited hospitals in England and on the continent.

Upon completion of fifty years as a practicing physician, Dr. Pierpont was presented with a plaque by the county society and the sisters and nurses of the Pensacola Hospital.

During the present war he served as chairman of a committee to collect surgical instruments for Great Britain and made five shipments aggregating 535 pounds.

Surviving Dr. Pierpont are his wife; two daughters, Miss Margery Pierpont of Saratoga Springs, N. Y., and Mrs. Florence Marple, Pensacola; one son, A. Warren Pierpont of Jacksonville; and three grandchildren, Martha Pierpont and Constance and Margery Marple.

### JULIAN COHEN CHANDLER

Dr. Julian C. Chandler of Tampa died on May 20, 1943, at the age of 65.

A native of Commerce, Ga., Dr. Chandler was graduated from the University of Georgia in 1904 and from Emory Medical College in 1910. He came to Florida and practiced for some time in Palatka. He then moved to New Orleans where for three years he specialized in eye, ear, nose and throat work at the Charity Hospital.

In 1916 Dr. Chandler opened offices in Tampa, where he practiced his specialty until the time of his last illness. He was a member of the Hillsborough County Medical Society and the Florida Medical Association, and a Fellow of the American Medical Association. He was also a member of the local Kiwanis Club, the Knights of Pythias, and of the Chamber of Commerce.

Surviving are his widow, Mrs. Ann Parsons Chandler; one daughter, Miss Hope Chandler; six sisters, Mrs. Fayette Simms, Winder, Ga.; Mrs. W. D. Smith, Commerce, Ga.; Mrs. W. F. Adams, Mansfield, Ga.; Mrs. F. C. Holliday, Lexington, Ga.; Miss Clyde Chandler, Tallahassee, and Miss Flora Chandler, Miami; and one brother, Dr. I. W. Chandler of Avon Park.

### COMPONENT COUNTY SOCIETIES

#### DADE

The Dade County Medical Society held its regular meeting on July 6 at the Jackson Memorial Hospital. The following papers were read: "Intervertebral Disk," by Dr. Ferdinand Vogt, and "A New Type of Bartonella Infection in Man?" by Drs. Thomas O. Otto and Philipp Rezek.

#### PINELLAS

The Pinellas County Medical Society held its regular monthly dinner meeting on the evening of June 4 at the Army & Navy Club. Dr. A. J. Bieker was principal speaker.

Dr. R. D. Murphy was host to the society at a round table assembly held at his home on June 18. He also acted as moderator. Military medical officers and nurses were invited to be present.

### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

ERYTHROCYTE SEDIMENTATION RATE DETERMINATION ON NORMAL YOUTHS, ROCHE, C. FREDERIC; STANNUS, DONALD G., AND ISBERG, EMIL M., MIAMI BEACH, J. LAB. & CLIN. MED. 28: 297-298 (DEC.) 1942.

In order to ascertain the normal sedimentation rate of youths in Miami Beach, 100 students were tested.

The Rourke-Ernstene corrected sedimentation technic was used. Of the 100 healthy youths in the series, 60 were boys and 40 girls. The ages ranged from 11 to 17 years. The corrected sedimentation rates ranged from 0.09 mm. per minute to 2.0 mm. per minute. The mean rate was 0.46 mm. per minute. Seventy-five per cent of all the determinations were below 0.65 mm. per minute, whereas Rourke-Ernstene placed the value of 0.35 per minute as the upper limit of the normal.

The authors propose that the upper limit of normal for the Rourke-Ernstene sedimentation index for South Florida be extended to 0.65 mm. per minute.

A CASE OF ADRENAL CORTICAL TUMOR WITHOUT ENDOCRINOLOGICAL SYMPTOMS, LOEB, MARTIN J., NEW YORK, J. UROL. 45: 785-793 (MAY) 1941.

Hyperplasia or tumor of the adrenal glands does not cause endocrinologic symptoms in all cases. Kurzrock believed that in carcinoma of the adrenal cortex only from 60 to 70 per cent of the patients have these symptoms. A case in which they were absent but evidence of malignancy was manifest is reported by the author.

After reviewing the physiology of the adrenal gland, Loeb pointed out that an excess of hormone produced by the cortex will cause suprarenal-genital syndromes (Gallais) which Schneider and Schmidt classified in the following groups:

- A. Sexual precosity.
- B. Pseudohermaphroditism.
- C. Change of sexual character after maturity.
- D. Achard-Thiers syndrome (pluriglandular disturbances).

- E. Postmenopausal virilism.

These changes are more common in women. The underlying changes are malignant tumors or hyperplasia of the cortex.

The suprarenal-genital syndrome is characterized by endocrinial imbalance, pigmentation, obesity, hypertrichosis, male voice, loss of menstruation and psychic disturbances. In men feminization and homosexual tendencies may occur.

In the case described by the author, a woman aged 48, had in two years gradually lost 40 pounds. She tired quickly and experienced pain in the left flank. Physical examination disclosed no abnormalities except a large abdominal mass, felt below the ribs, which descended into the right side of the pelvis. A roentgenogram of the abdomen revealed considerable displacement of the right kidney and compression of the gall-bladder. The result of cystoscopic examination was negative except that it disclosed a small stone in the bladder. Bilateral pyelograms showed the right kidney to be displaced downward and transversely so that the lower pole faced the spine and the pelvis looked upward. Barium enema showed no colonic irregularity. A roentgenogram made after perirenal insufflation revealed a retroperitoneal mass above the kidney. The blood chemistry was normal. Gastric analysis revealed a few red and white blood cells and a trace of lactic acid. Urinalysis was negative except for 3 plus albumin; examination of the feces gave negative results. The preoperative diagnosis was possible cortical tumor of the right adrenal gland. Under spinal anesthesia a tumor weighing 2 1/4 pounds was removed, which microscopic examination proved to be a hypernephroma of the adrenal cortex. The patient recovered uneventfully and, three and one-half years later, is in good condition.

#### ADVERTISERS' NOTES

##### ANY PHYSICIAN MAY EXHIBIT "WHEN BOBBY GOES TO SCHOOL" TO THE PUBLIC

Under the rules laid down by the American Academy of Pediatrics, their educational-to-the-public film, "When Bobby Goes to School," may be exhibited to the public by any licensed physician in the United States.

All that is required is that he obtain the endorsement by any officer of his county medical society. Endorsement blanks for this purpose may be obtained on application to the distributor, Mead, Johnson & Company, Evansville, Indiana.

Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film in advance of public showings in the community.

"When Bobby Goes to School" is a 16-mm. sound film, free from advertising, dealing with the health appraisal of the school child, and may be borrowed without charge or obligation on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

#### TETANUS IMMUNIZATION OF MILITARY PERSONNEL

All military personnel on induction are being immunized against tetanus either, as in the Army, by three injections of fluid toxoid, or as in the Navy and Marine Corps, by two injections of alum precipitated toxoid (New Eng. J. Med., 227: 162, 1942). In addition a small or stimulating dose is injected prior to departure for a theater of operations and an emergency dose is given to those wounded or burned in battle or incurring other wounds likely to be contaminated with Clostridium tetani. According to recent report (Am. J. Pub. Health, 33: 53, 1943) since June, 1941, when the present tetanus immunization program was adopted, there have been but 4 cases reported from the entire Army, and none of these were in immunized individuals. Although perhaps too early in the present war to draw any conclusions, it is of particular interest that no cases of tetanus have been reported from battle casualties.

For civilian use, especially in children, it is of decided advantage to accomplish simultaneous immunization against tetanus and diphtheria. Combined Diphtheria Toxoid-Tetanus Toxid, Alum Precipitated, Lilly, is designed for prophylaxis only, affords effective immunity against both diseases, and avoids risk of serum sensitization which may follow use of an antitoxin.

#### AMERICAN HOME PRODUCTS CORP.

Alvin G. Brush, chairman of American Home Products Corporation, manufacturer of drugs, foods and household products, today announced an expansion in the field of biological products through the affiliation of E. E. Bartos, Inc. of Locust Valley, N. Y., with Reichel Laboratories, Inc., American Home Products subsidiary.

The Bartos Company manufactures and distributes an unique and streamlined method for determining protein allergies through intracutaneous injections. Put out in a compact kit for doctors, the Bartos System permits making tests for protein allergies at one time, and with one hypodermic needle.

Manufacture of these products will be transferred to the Reichel Laboratories at Kimberton, Pa., and will be directed there by Dr. John Reichel, head of the laboratory bearing his name and for years an outstanding figure in the biological and scientific field.

The Bartos products will be marketed under the name of Reichel Laboratories Allergins—Bartos System. Elmer E. Bartos, founder of the system, will join the Reichel sales staff and will assist in a nationwide selling program to the medical profession.

Reichel Laboratories is one of the nation's leading producers of dried blood plasma for the nation's armed forces. It also is turning out large quantities of typhus vaccines on government orders, and is operating 100% on war work.

The Bartos acquisition is the third expansion step taken by American Home Products this year as part of a long-range diversification program. On March 1, Ayerst, McKenna & Harrison Limited, leading Canadian producer of biological and pharmaceutical products, and its American affiliate became part of American Home Products. Last month the corporation acquired the G. Washington Coffee Refining Company, pioneer in the field of instant coffee.

#### POLAROID PRESCRIPTION BLANKS

Polaroid prescription blanks for single and double vision prescriptions are now announced by American Optical Company.

These blanks are 50 mm. round, 8 mm. thick, 6.00 curve. Stocks of polaroid blanks for single vision prescriptions are ample and immediate delivery can be made.

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## THE NATIONAL CONVENTION

Dear Co-workers:

Just having returned from the National Convention in Chicago, held June 7, 8 and 9, I am filled with enthusiasm. I wish I might give to each of you a little of this feeling of encouragement and hope, which is so sadly needed during these days of uncertainties.

In spite of the war and war conditions, or shall we say because of such conditions, there seems to exist a much closer feeling of fellowship and neighborliness. Could it be that our concentrated effort on one main objective, maintaining our way of living, has drawn us closer together? At least, from any and every angle, the convention was a success.

A message to us from the president of the American Medical Association, Brigadier General Fred Rankin, was an outstanding event as was that of Dr. Morris Fishbein, editor of *Hygeia*. These men brought home to us, as never before, the great need for the Woman's Auxiliary. During these times and those to come immediately after the war, every doctor's wife should resolve to stand loyally behind her husband's profession. Interest in her country's physical and mental condition should be her first concern. This is her patriotic duty.

No finer welcome was ever given any group than that conveyed by Mayor Kelly of Chicago. He spoke of the great influence such an organization as ours could have in guarding our political

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It happens that millions of Americans attach a special value to their right to

enjoy a refreshing glass of beer . . . in the company of good friends . . . with wholesome American food . . . as a beverage of moderation after a good day's work.

A glass of beer—a small thing, surely—not of crucial importance to any of us. And yet—morale is a lot of little things like this.

Little things that help to lift the spirit, keep up the courage. Little things that are part and parcel of our own American way of life.

And, after all, aren't they among the things we fight for?

MORALE IS A LOT OF LITTLE THINGS

(as you, Doctor, know better than most)



heritages. He asked us to be ever alert in our own groups, and in others with which we are affiliated, to prevent legislation of a fallacious nature.

A message from our past president, Mrs. Frank N. Haggard, filled us with an earnest desire to carry on, united in aim and spirit, through all trials and tribulations that befront us. To our new president, Mrs. Eben Carey, we pledged our wholehearted support through the difficult year before her.

Not least among our pleasant memories is that of meeting our central office secretary, Miss Wolfe. Her friendliness, grace, and charm will make all contacts with the central office a pleasure indeed.

How I do wish that every one of you might have had the privilege and pleasure of attending the National Convention. I thank you for sending me as your president, and hope that a little bit of my enthusiasm may be carried over to you.

Please make plans now to hold your auxiliary intact this coming year. Plan early and wisely according to your locality and people. Do not try to do too much, but rather a small amount of worthwhile work. Send me the names of your new officers, please. Copies of the new charges will reach you late in July. Follow them as closely as possible. Do not hesitate to write to me if you have problems and difficulties. I shall be glad to give any assistance within my ability. Should there be a possibility of organizing new groups, even during these trying times, contact me, please. I will see what can be done to assist you in your efforts.

May you have a pleasant summer.

LYDIA KRUEGER (MRS. F. W.)  
*President.*



#### DUVAL AUXILIARY

The June meeting of the Woman's Auxiliary to the Duval County Medical Society was held in the home of the president, Mrs. J. W. Hayes, with Mrs. Charles Henley serving as co-hostess.

Annual reports from officers and committee chairmen were outstanding. Of special interest was the report of the defense chairman, Mrs. Charles Henley, who presented a detailed report of all the activities accomplished by her committee during the year. She stated that a party had been given for 200 service men at the Waterworks Recreational Center, a day room in the Duval

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County Armory had been redecorated, and a day room at Jacksonville Beach had been completely furnished for use by service men stationed there. A rising vote of thanks was extended Mrs. Henley and her committee for this splendid report.

The report of the president, Mrs. J. W. Hayes, was accepted with a rising vote of thanks for her outstanding achievements during the year.

The following officers were elected to serve during the coming year, 1943-1944: Mrs. J. W. Hayes, president; Mrs. E. W. Veal, vice president; Mrs. C. W. Johnston, secretary; Mrs. Gordon Ira, treasurer.

Welcomed at the meeting were several former members whose husbands are now in active service and stationed away from Jacksonville.

During the social hour members were invited into the dining room where delicious refreshments were served from a beautifully appointed table overlaid with an exquisite lace cover and centered with a lovely arrangement of spring flowers; tall white tapers in crystal candelabra stood at either end. Mrs. Gordon H. Ira and Mrs. Raymond King presided over the punch bowl.

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## STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETINGS
Florida Medical Association.....	Eugene G. Peek, Ocala.....	Shaler Richardson, Jacksonville.....	To Be Announced
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville....	" " "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach..	" " "	Miami, Postponed
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg.....	Kenneth Phillips, Miami.....	To Be Announced
Dental Society, State.....	A. Malcolm Smith, D.D.S., Tampa	H. L. Cartee, D.D.S., Miami.....	To Be Announced
Derm. and Syph., Soc. of.....	Wiley M. Sams, Miami.....	Lauren M. Sompayrac, Jacksonville	Miami, October, 1943
East Coast Medical Association.....	T. C. Kenaston, Cocoa.....	I. M. Hay, Melbourne.....	Postponed
Hospital Association.....	Mr. W. E. Arnold, Jacksonville.....	Miss Katharine Moyer, Lake Wales.....	
Industrial Surgeons, Assn. of.....	Frank D. Gray, Orlando.....	Richard H. Walker, Orlando.....	To Be Announced
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville.....	Chairman	
Nurses Association, State.....	Mrs. Ann Thompson, Leesburg.....	Miss Madalee Hazel, St. Petersburg	To Be Announced
Ophthal. & Otol., Soc. of.....	Shaler Richardson, Jacksonville.....	C. E. Dunaway, Miami.....	To Be Announced
Pathological Society.....	L. Y. Dyrenforth, Jacksonville.....	Iva C. Youmans, Miami.....	To Be Announced
Pediatric Society.....	Ludo von Meysenbug, Daytona B.	Robert Blessing, Ft. Lauderdale.....	To Be Announced
Pharmaceutical Association, State	Mr. H. B. Douglas, Bonifay.....	Mr. R. Q. Richards, Ft. Myers.....	Miami, To Be Announced
Public Health Association.....	Leland H. Dame, Sanford.....	E. M. L'Engle, Jacksonville.....	
Radiological Society .....	John N. Moore, Ocala.....	Walter A. Weed, Orlando.....	To Be Announced
Railway Surgeons' Association.....	Frank D. Gray, Orlando.....	W. C. Page, Cocoa .....	To Be Announced
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales.....	Mrs. May Pynchon, Jacksonville.....	
Chattahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville.....	Postponed
Gulf Coast Clinical Society.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	Postponed
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola.....	Kenneth Phillips, Miami.....	
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans.....	B. T. Beasley, Atlanta.....	Postponed
Southern Medical Association.....	Harvey F. Garrison, Jackson, Miss.	Mr. C. P. Loranz, Birmingham.....	Cincinnati, Nov. 16-18, 1943
Suwannee River Medical Society.....	L. J. Arnold, Jr., Lake City.....	H. S. Howell, Lake City.....	

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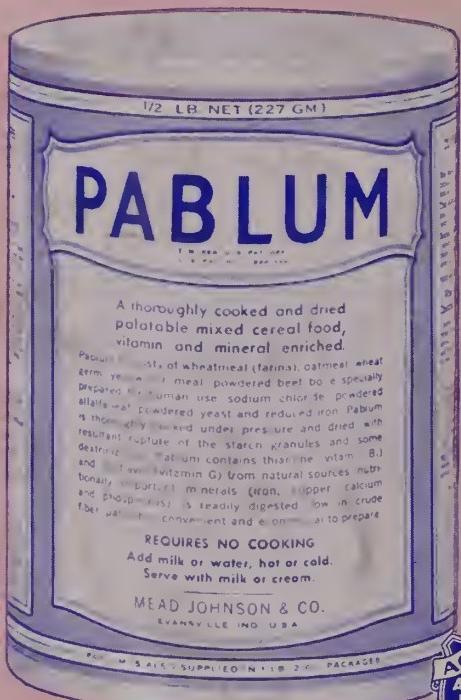
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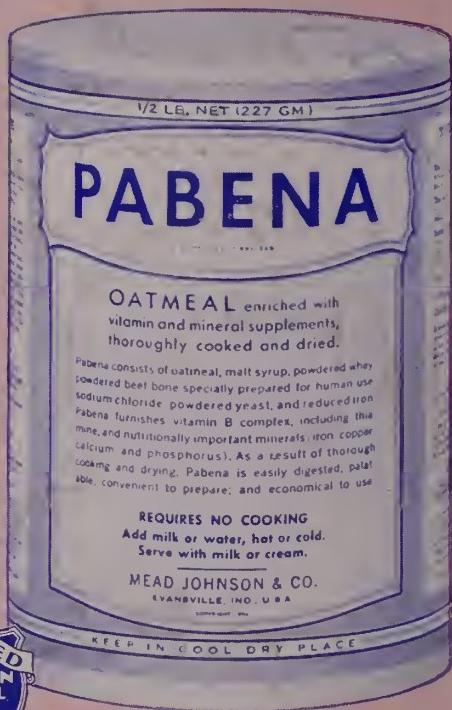
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Vol. XXX

SEPTEMBER, 1943

No. 3

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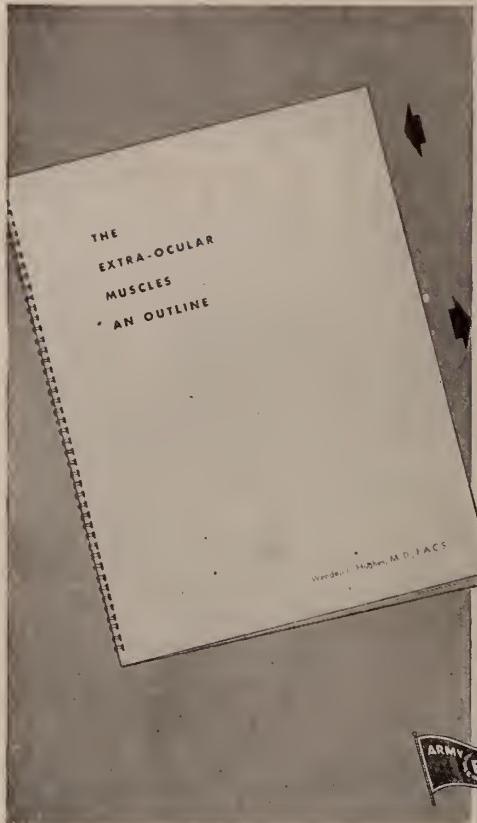


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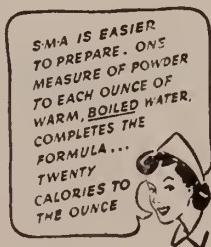
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## MEDICAL STEWARDSHIP IN WAR AND PEACE

C. W. ROBERTS, M. D.  
ATLANTA

In spite of the fact that a certain section of public opinion holds that the American Medical Association is a business seeking primarily to advance the material welfare of its members, those who comprise the membership know that such a conclusion will not stand up under the clear light of unbiased analysis. That section of our Constitution and By-Laws which states, "The objects of the Association are to promote the science and art of medicine and the betterment of public health" is not, as our critics would claim, mere window dressing. We seek, in fact, so to direct the policies of medicine as to provide the greatest possible measure of protection of the public health, regardless of the effect such policies may have on the physician's economic status.

In the care of patients, the physician is and must remain an individualist. This distinction is truly characteristic because the urgency of the problems that are thrust upon him precludes deferment of action until consultation can be had with some directing bureau. He is on his own, and his value to society is in direct ratio to the degree in which his background and training provide for the exercise of this sterling quality of independent resourcefulness. Notwithstanding, the medical profession is a great fraternity, which is another way of saying that community action, the voluntary relinquishing of individual rights in order that the welfare of the many may be served, is not only widely accepted among us, but represents, in fact, a traditional principle of medicine long committing it to the acceptance of a full measure of social responsibility. All agree that the objects of the profession rightly include social and financial considerations, but its crux, its historic fundamental, is one of service convincingly manifested by the selfnegation which characterizes its followers. Monetary rewards are secondary and never a substitute for the satisfactions that flow from the performance of the duties which medicine's ideals and ethics impose.

Medicine is a calling based upon ethical principles preserved by sacred traditions and guided by equitable policies which seek primarily to protect the public welfare. On this foundation we must stand. But let me hasten to deny that in thus again committing medicine to its historic policy of service through individual initiative, unfettered by legalistic control, to patients and institutions enjoying the right of free choice, I am in sympathy with that minority of leaders who would resist the inevitable impact which social changes have made and are making in all business, services and professions alike. Such groups, including ours, have, over the years and as has seemed necessary, been engaged in a reappraisal of their practices in order that adaptation to changing social standards might be made. Medicine has stood firmly against revolutionary proposals and against plans and panaceas under any sponsorship masquerading as the people's benefactor, and hiding behind a theoretically plausible facade, a sure high measure of public exploitation. This stand is a fortress that we must not yield.

Let us admit that a large and perhaps increasing segment of society has questioned a willingness on the part of medicine's leadership to accept social change. Being out of step with the times is freely charged. Lack of social vision, dangerously abbreviated perception bound by the barnacles of habit, failure to appreciate medicine's new role in the world revolution, these and a host of other unkind and undeserved darts are being hurled at our collective profession. I say they are unkind and undeserved when applied without reservation. But how are we to explain the growing critical attitude of the American people and of a loudly vocal, if not numerically large, segment of our membership unless we frankly confess that there are in our ranks three groups, each holding views somewhat at variance with the other?

May I venture a definition of these groups? At one extreme is the ultraconservative, who sees danger to the people's free system of medicine lurking behind every proposal, regardless of source or authorship. This group has too little faith in humanity and has forgotten a lesson in American history which should ever be remem-

bered, illustrated by the pioneers who dared to break with the traditions of the past and to build a philosophy suited to the demands of the age and environment in which they lived.

The other extreme is championed by the ultraliberals, who seem to be at the mercy of currents of thought which they embrace without critical analysis or logical appraisement. To be charitable, let us believe that they hold honest convictions, arrived at through emotional patterns, partaking too little of reality or common sense.

Before proceeding to a consideration of the third group, the so-called middle-of-the-roaders, I express the conviction that there is little to justify a choice between the conservative and the liberal so far as the influence which their thinking confers upon the solution of medicine's economic problems is concerned. The conservative is smug and satisfied because of the order of his rugged individualism. He is secondarily concerned with the complex problem of community and world brotherhood, except in rare instances. His uncompromising honesty hurts the cause and provokes resistance through lack of sympathy and intolerance. The liberal, gay and pyknic of mien because the head is carried above the level of life where reality sobers men, inadvertently engages in the apparently harmless pastime of beating the drums for the revolutionist, who either thoughtlessly or by cunning seeks selfish ends under the guise of social betterment. It is out of the rash activities and the finesse, or lack of it, of these extreme groups that much of the criticism of medicine springs. Such commotion is seized upon as the prevailing attitude of medicine toward today's social obligations. Our critics refuse to consider the constructive efforts which have been made and which are now proceeding with quickened pace to rid medicine of its acknowledged deficiencies and to mold it through sound modifications in policy and method to meet the changing world about us.

Coming now to a discussion of the viewpoint of the majority representing, as I have said, the third and largest of the arbitrary segments into which I have presumed to classify our membership, I again venture to suggest a few qualities which seem to me to be characteristic of its processes of thinking. I have referred to this large group as pursuing a course between two extremes, seeking to avoid the inefficiency of unbending individualism on the one hand and the tyranny of state medicine on the other. Such a

course is, as you well know, not a charted road at all, but an attitude of mind holding with one hand to the principles upon which American medicine has been built and reaching with the other to grasp the hands of those in and out of the profession who have ideas of genuine value to offer.

The members of this group do not require that experiments in the field of medical economics shall first be proved, for they realize that the data of experience are only now being made. They insist, however, upon sound principles and freedom from public hazard insofar as these are capable of predetermination. Moreover, they strive to see the problems of medicine from the viewpoint of the average physician, who touches the public about center. They know that medicine is not a vested interest, but a public service in which all people are entitled to share. They realize that the present system of private medicine will survive only as long as its benefits, expanding with every new discovery, can be delivered to those who seek it, regardless of economic status. They appreciate that health is a commodity not reserved for the affluent, but rather an essential service purchasable where the will and the means exist. Too, they are conscious of the premium which rests upon physical fitness as a qualification for employment. Knowing also that the mounting cost of medical care is already a major item in the budget of many and of catastrophic proportions to some, they realize that the problem demands definitive attack. They seek to persuade the membership and the overly anxious patient alike that dress suit medicine is an expendable luxury, not in any way superior to the less expensive bedside variety which antedated the age of laboratory and gadget diagnosis now concerned too much with instruments and too little with the art so successfully used by our fathers.

Can medicine, then, be depended upon to measure up to its mounting responsibility? Certainly this question, long one of debate in the councils of medical statesmanship and medical economics, is being more urgently posed because of the war and is destined to loom ever larger in the period immediately to follow the coming of peace, when all of our institutions will be called upon to make major contributions to world reconstruction.

Here, then, is a picture of medicine in a world of contending theories and philosophies,

showing healthy differences of opinion with regard to the methods to be employed in meeting its social obligations, but united in awareness of the problems and desirous of forthrightly seeking their solution. Nor are the differences of opinion, as represented by the groups defined, peculiar to the citizenry which happens by choice to make up the membership of the American Medical Association. Group thinking and group action have their counterpart in all the trades and occupations making up the body politic. Belief in one or another of the suggested philosophies when applied to government, leads to party affiliation and through mass movement seeks to gain certain desired ends. It is the American way, through which the democratic process is kept alive and the people's will is written into law. This is government by and for the people. Representatives sit in the national Congress just so long as they translate the will of their constituents into law. In like manner the policies of medicine are made or modified by our House of Delegates, composed of elected representatives from constituent associations. If these policies are not a true reflection of the opinions and the wishes of the profession, the machinery exists through which redress can be had.

The House of Delegates of the Association is made up of one hundred and seventy-five representatives. They constitute the parliament of American medicine. Speaking for all of the profession of this country, as chosen delegates, they make and preserve the policies which guide us in our professional and civic relations. It is a thoroughly democratic body governed by strict but fairly administered parliamentary procedure. Its actions are neither dictated nor controlled by any group. The officers of the Association, including the headquarters organization, loosely spoken of by the uninformed and by those who would divide us as the hierarchy of medicine, are the servants of American medicine, who act, except when they speak as individuals, in strict accord with the approved policies of the House of Delegates. These facts are not generally known, or, if known, are too often discounted.

Speaking as one who has been privileged to sit in fifteen sessions of the House, I express these convictions in the hope that my testimony may reassure those who have entertained doubt. I would even hope that those who speak loosely and without regard to truth might investigate anew. The sessions of the House are open to all.

Through your delegates you have access to it for the presentation of such views as you believe are good for American medicine. None are barred because they are called radical. None are favored because they are considered conservative. The House is an open forum where the problems of medicine are debated and where policies are made in accordance with the democratic principle of majority rule. There is only one yardstick which controls conduct with regard to a given question or a personal position. By it all matters are measured and all advocates judged, be they of the affluent or the neglected strata of life. I refer to the yardstick which weighs the effect of a given question upon the quality of medical care and its availability for all, regardless of economic status. By this criterion alone the bottlenecks of debate are resolved. Moreover, it is the yardstick which preserves our principles of medical ethics and the idealism that has made us an altruistic profession. So long as these fundamentals are watched and the esprit de corps of medicine is accepted and practiced by its members, mere court opinions cannot rob us of a professional status. The outward forms of medicine will change, should change, are changing. But its heart, if we are wise, will remain faithful to the Hippocratic Oath. Against this spirit the edicts of law can never prevail.

But medicine has perhaps been too sensitive, or too much inclined to rest upon its oars. The time has come when our deficiencies must be acknowledged. The way must be found to accomplish more in the field of medical economics through the acceptance of the principles of community action. Isolationism in medicine is as outmoded as it is in the field of foreign relations. The care of medically indigent patients and those of moderate income experiencing catastrophic illness is a problem of community action to be accomplished through pooling of community assets. We cannot longer permit this problem to go unsolved for it is the source of our most damaging criticism and the inspiration for most of the efforts of the socially inclined, both in and out of government, to legislate in the field of medicine.

Thus far I have, without concealed effort and without apology, referred to the well known fact that there are differences of opinion in our profession with particular regard to the question of virile leadership in a period of changing values, as well as in the field of medical economics. There is a tendency in some quarters to place respon-

sibility for action, or lack of it, on certain members of the headquarters group of our Association who are presumed to be clothed with authority to speak in the name of American medicine, unhampered by the established pronouncements of the House of Delegates. Granting that because of the human element of ill advised interference such violations may on occasion be sustained, I am prepared to express the opinion, based on an intimate knowledge of the conduct of the Association's affairs in the House of Delegates and in the Board of Trustees, that zealous effort is at all times made to see to it that the acts and pronouncements of the Association's officers and official bodies conform, both in spirit and in the letter, to the wishes of the Association's members, as expressed by the official actions of the House.

Naturally, officials of the Association have the right to speak as individuals when they feel so inclined and to express personal views which may be at variance with the official rulings of our policy-making body, but a common error is the acceptance of these off the record, or personal, opinions as being faithful interpretations of established policy. Such errors should be avoided in the interest of harmony and in the spirit of fair play. The truth is that our code of ethics and our laws as approved by the House of Delegates governing our relation to the public and with each other are more in the nature of principles than ironclad blueprints.

A moment's reflection will suggest the wisdom of such standards. Conditions and circumstances surrounding a given question vary in different jurisdictions. Extenuating circumstances may lead to the adoption of a course of action as just in one section, whereas the absence of such considerations would veto a similar course in another. When it is borne in mind that it is the public's interest that medicine everywhere is primarily commissioned to serve, it becomes apparent that no rules of conduct or standards of procedure that are in conflict with such primary intent, could with consistency be maintained. It is because medicine accepts this central truth and urges its faithful application that our governing bodies, state and national, have always refrained from inflexible enunciations. Reduced to its essence, medical organization in this country is in spirit and in fact decentralized, with responsibility placed where it belongs, on the level of the state

and county medical society. Only general principles are established by the national body, and even these are subject to modification when, in the judgment of a state or county society, local circumstances require it.

With these considerations in mind, it becomes easier to understand why the national Association has been subject to so much criticism with regard to its leadership in certain fields. Faithful to its organizational design, the leadership of medicine has made no attempt to establish a strong centralized body with powers in excess of those delegated to it by the House of Delegates. Fearing governmental interference with private practice, some have desired a more vigorous campaign of resistance to such federal projects as have included medical features. Convinced that compulsory health insurance was in the making, others have felt that plans of practice utilizing the insurance principle and under private medical control should be set up after some general plan formulated in Chicago. A few, influenced by the glowing reports on socialized medical schemes from abroad, made to appear as the long-awaited answer to America's problems of medical inadequacy by certain of our social planners, have favored outright capitulation and open official endorsement. Still others have been content to drift, counseling an attitude of aloofness and begrudging every constructive step which has been made by medicine's representatives to meet and consider in a spirit of fairness the proposals of those who have advocated change in the delivery of medical care.

Under such circumstances and holding fast to fundamental concepts and an unfaltering belief in the free system of medical practice, the leadership of medicine has, from year to year, crystallized the wishes of the membership into such additional principles and methods as the gradual evolution of medicine and the needs of the country have made advisable, including its policy towards a government undeniably sympathetic with the idea of broader social reform. A vast amount of constructive work has been accomplished, all in the framework of the American democratic system and surrounded by those safeguards which, while discouraging medical exploitation in the name of social reform, have yet pointed the way in methods and technic adequate to the requirements of those subcomfort groups willing to cooperate by making such personal contributions as their means would permit. This, in essence, is the philosophy which underlies the formation of any

plans designed for the better care of the low-income groups.

Before 1935, while there was considerable interest on the part of organized medicine with respect to plans of medical care, effort was nevertheless uncoordinated, and was put forth in widely separated areas. There was no forthright sanction of such a departure from orthodox medicine by the profession generally. Here it is recorded with pride that the Fulton County Medical Society of Georgia was among the first, if not the very first, county medical society to give form and purpose to its interest in a concrete plan for the distribution of medical care.

The American Medical Association, while tolerant of effort in this direction, was content to pursue a policy of watchful waiting. It sensed the immensity of the problem, but was apprehensive of later developments, being mindful of European experiences in this field. Late in 1935, however, when the Social Security Law was under consideration, a special meeting of the House of Delegates was called to consider this problem in all of its aspects and implications. This body found nothing objectionable in the pooling of resources for medical care by using the insurance principle, but felt that certain guiding principles should be laid down to govern the activities of local societies. It, therefore, adopted ten principles on which all such undertakings were to be based. The formation of this set of rules spoken of as the "Ten Commandments" was the impetus to the rapid development of plans throughout the country so that soon some two hundred were developed in connection with state and county medical societies. All these plans undertook to conform to these established principles and were safeguarded by professional control, no third party intervention, freedom of choice of physician and no limitation with respect to preventive or curative medical care.

The principle of charges based upon the ability of the patient was a prominent feature. This movement toward voluntary provision of plans for medical care was now well under way, and organized medicine recognized its value as a powerful influence to repel the advocates of more radical schemes. State and county medical societies were advised to study the needs of their local communities and to provide the necessary facilities.

After the meeting of the President's Interdepartmental Committee in the summer of 1938,

another extraordinary session of the House of Delegates was called to consider the implications of the proposals of this committee. Out of this session came endorsement of hospital insurance, compensation insurance and a recommendation that the indemnity form of insurance be developed to aid low income groups in the provision of medical care. Following this session of the House of Delegates the attitude of organized medicine toward the development of plans under state and county auspices passed from the station of tolerance and of recommendation to that of forthright appeal to constituent associations to give immediate and studied care to this problem. While it may be acknowledged that all these plans are for the moment in the experimental stage and that they may not yet prove to be the solution sought, they are departures in the right direction and enjoy the support of a majority of the membership of our Association.

Medicine does not believe in governmental paternalism. Medicine does favor helping those who are willing to help themselves. Every step made in the field of medical economics has been guided by this golden principle. To yield on this point and to open the country's goods and services to the caprices of the indolent would not only be socially unsound, but would be destined to create medical indigency instead of contributing to its elimination.

In 1937 the House met in extraordinary session for the consideration of pressing economic questions. The attitude of medicine was again expressed in that remarkable document since known as "The Platform of American Medicine." It is worth quoting, but time does not permit. Let it suffice that it is fair, complete, adequate and, from the standpoint of medical statesmanship, worthy of a place in the world's archives where are preserved its Magna Chartas. Under its liberal provisions and in the spirit of its equitable treatment will be found not only official approval of such schemes as are considered necessary to meet local needs in the jurisdictions of the various constituent associations, but tested governing principles to be used in developing techniques through which to implement the plan or plans chosen for a given community. I cannot refrain from expressing the conviction that criticism for lack of community planning adequate to meet the needs for complete medical care should fall, not upon the type of leadership in the House of Delegates nor upon the headquarters group in Chi-

cago, but instead upon constituent associations where responsibility primarily rests. Principles and technics have been formulated and approved. Their adaptation to local needs is the function of state and county societies.

Fixed convictions regarding the effect of centralized control upon the quality of medical care has led to consistent and unabating resistance to such proposals as compulsory health insurance, but our efforts in this field have been interpreted by sections of the public and by the press as having an ulterior motive. The Supreme Court, in the case of the United States against the American Medical Association and the Medical Society of the District of Columbia, held among other things that "their purpose was to prevent anyone from taking employment under group health," and that they "were interested solely in prevention of the operation of a business." In spite of this decision and without any intention to question the verdict, it is but truthful to say that the policy upon which our organizations proceeded and the agencies employed in the actions which were made the basis of the indictment, were not intended to hurt but rather to protect the public welfare. Notwithstanding, the Court held that the methods employed did, in fact, controvert the rights of the petitioners and were, therefore, unlawful. How the profession is to proceed in the face of this decision and in consonance with its carefully devised policies to protect the public against unsound proposals and exploitation in the field of planning for community medical care is difficult to determine. The rules and regulations which we have set up, conceived to be in the public interest, were never intended to have the force of law, but rather are guides to conduct. If their literal application as presently written is subject to question, they should and will be clarified. In the meantime, in the application of the Association's policies, care must be exercised to see that rights guaranteed under law are not abridged.

Time will allow a brief reference to only a few of the more recent steps taken to place the full facilities of American medicine behind the war effort and to safeguard the interests of our members, both now and in the postwar period. The House of Delegates met in New York in June 1940 just after the fall of France. It was then apparent that our entrance into the conflict was only a matter of time. A special committee, clothed with full authority to act in the emergency, was set up with instructions to offer to the govern-

ment the services of the Association's entire membership, together with such facilities, records, bureaus or headquarters personnel as might be helpful in preparations to resist aggression. The offer was accepted, and many helpful contributions were made. This work was largely under the guidance of the Committee on Medical Preparedness.

At the Cleveland session the following June, with the dogs of war now ever nearer our shores, the Committee on Procurement and Assignment was authorized. The activities of this agency in supplying personnel to the armed forces without delay and in full, as well as in protecting the civilian population against undue depletion of medical and ancillary services, are a familiar story in current history. In spite of some lapses in administrative judgment, with ensuing hardships here and there, the over-all work of this committee must go strongly on the credit side of the ledger.

A more recently formed committee, temporarily authorized by the Board of Trustees, proposes to deal with the problem of postgraduate education, especially directed at our members in military service. The purpose is to keep them in touch with advances in clinical medicine and is to be achieved by short, intensive courses given by recognized authorities in strategic centers throughout the country. The civilian profession will be expected to enroll for these meetings.

Still another committee on postwar medical services just now engaged in the preliminary phase of organization has been authorized. This committee, in the development of its program, proposes to deal with the problems of medicine in the postwar period on both a national and an international basis. Much emphasis will be placed on such problems as are likely to face the members of our profession when they return to civilian practice, as well as the obligation which victory must inevitably place upon us and the professions of our allies to help in the rehabilitation of the impoverished services of the peoples of our enemies. The scope of the program visualized is breath-taking, but illustrative of the fact that American medicine is not lacking either in vision or courage.

With somewhat similar purpose, but with some less territorial scope, The Carlos-Finlay Institute of the Americas deserves priority mention. While in no wise an agency of our Association, its program merits and receives the endorsement of our leadership. Privately supported, this foundation seeks to coordinate and mobilize the leaders

of the medical profession and its supporting industries for the purpose of planning for postwar medical services. A meeting under the auspices of this institute with the American Medical Association as a sponsor was held in New York on March 15 of this year. There were outstanding accomplishments, a portent of greater things to come. Other illustrations supporting the thesis that medical leadership at the national level is not asleep are well nigh limitless, but these must suffice.

And now, let me return in conclusion to the leaders of medicine in constituent states and component county societies. We are a federacy governed in matters of general policy by regulations approved in the House of Delegates, but self governing in local matters. Our achievements and our deficiencies are of our mutual making. Things as they are are because of what we have done or left undone; reforms where needed and new protections for the physician's prerogatives must and should begin at the bottom amongst the doctors and the people they serve rather than at the top. It is in the field that heart throbs and longings are most easily sensed. There is perhaps need of seeing to it that these longings reach the ears of our policy-making groups. This is the democratic way, slow, but free from the tyrannies of government imposed from above. Many still cling through natural inheritance to the ideologies of an age when every man lived without let or hindrance within the narrow confines of his own "vine and fig tree." Certainly in a land where the average citizen has, through education, become acquainted with the cardinal inalienable rights, we can no longer expect the practice of the social concepts of the pioneer to solve the problems of our day.

World events bring into sharp focus the necessity of reviewing the attitude which our profession manifests toward those policies of citizenship which are the common responsibility of all without regard to occupation. These concern measures for the preservation of the American competitive system under free initiative with a guarantee of equal opportunity under law for all, regardless of color, race, or creed. Already sharp divergencies of view as to how this may be accomplished are appearing. That segment of opinion in this country which, it is claimed, expresses the view of the conservative, or more nearly that of the so-called rugged individualist, holds that the experience of our soldiers fighting

in the fox holes of our far flung battle lines and in the ships of sea and air, will cause them to return unswervingly conditioned to the philosophy of self reliance. They are, these say, on their own and live or die by the exercise or lack of exercise of independent action. Using the same argument, except in reverse, others say that these future citizens, who undoubtedly will shape the outlines of things to come in American ideology, will, because they have survived out of the lessons of teamwork, the dependence of one upon the co-operative efforts of another, champion not the cause of individualism, but rather the cause of community action. Thus the liberals amongst us see these future citizens and leaders ordered by a sense of quickened responsibility to do more for the collective interests of the country of which they are a part and possessed of a passion to preserve and improve society. Whether one supports the one or the other of these viewpoints, there are straws in the wind which suggest that medicine will do well to heed these rising currents of thought which are calculated to catch in their cross fire those institutions and personal service groups that fail to adapt their services to the changes which evolution brings.

Who, then, will shape postwar medicine? As believers in the private system of practice, it behooves us to be planning, analyzing and discussing. There are spots in our system that will not stand up in the spotlight of public opinion. There are differences that weaken us internally and open us to attack from outside. There is some truth in the charge that we pay only lip service to those pronouncements of our House of Delegates which obligate us to broaden our concepts and to take corrective action regarding questions of inadequacy in the field of medical economics and distribution of physicians. The acid test is whether medicine is able and willing to meet the demands which time and changing social concepts impose. As a profession we believe that we have the statesmanship to do the job. The necessary implements have been forged. There remains to be tested the question of willingness on the part of a sufficient number to apply themselves until definitive results have been achieved.

And now a word regarding the broader aspect of the physician's responsibility as a citizen. By virtue of the traditions of medicine and his unique hold upon the popular mind, the physician occupies a position of strategic importance in this crusade. By the same token, this potential power

for constructive leadership, if unwisely used, may become a subversive weapon of no mean proportions capable of feeding the flame of antisocial revolution. For this reason, the profession will do well to re-examine the structure of its policies and the impulses which motivate attitudes and practices, to see how they square with the weighty responsibility which destiny has placed upon it.

The tenets of the profession, which assert that medical science is universal, knows no color, race, or creed and requires of its followers a life of self negation in the public interest, will go far if faithfully observed in helping to gain that day when all of our peoples will live together in peace and in plenty. America has been, and will increasingly become, the melting pot of the peoples of all lands and all nationalities. Our paramount task will be to establish, as a primary quality of good citizenship, such a degree of tolerance and respect for the rights of all citizens as will permit the full enjoyment of those privileges guaranteed under our Bill of Rights. This task will not be easy. We shall find prejudices and conditioned hatreds, lusty antagonists. The selfish practices of certain groups striving to protect vested interests will continue to be countered by still other groups employing the same technics and motivated by the same selfish purposes. Race will be set against race, color against color and creed against creed; but if America is to solve its social problems and go forward under law, these remnants of the age of tooth and claw must be outlawed. If this be a Utopian dream, let us dream on lest we be awakened by the age old cries of those, who, having long suffered, finally seek their aims through civil revolution.

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#### WARNS OF CARBON TETRACHLORIDE

"The toxicity of carbon tetrachloride in cleaning solutions is still not as well known as it should be in view of the seriousness and extensiveness of poisoning which can result from the inhalation or absorption of this substance," The Journal of the American Medical Association for July 24 warns in answer to a query.

#### APPENDICITIS

##### RESULTS OF SURGICAL TREATMENT UNDER VARYING CONDITIONS AT THE DUVAL COUNTY HOSPITAL

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The purpose of the investigation herein reported was the study of all cases of appendicitis observed at the Duval County Hospital during three periods of one year each under varying conditions peculiar to these years. The first year extended from July 1936 to July 1937, when the plan of rotating internship, without residents, was in use. At that time the sulfonamides had not been generally employed, and certainly the powdered form had not yet been put into the abdomen. During the next period, extending from July 1938 to July 1939, the present resident system of internship was in use for the second year and was becoming established. The sulfonamides were even now not extensively used; sulfanilamide was available, and sulfapyridine was in the experimental stage. These drugs were not employed in the treatment of the cases of this series observed during these two periods. The third year included the period from July 1941 to July 1942. By this time the resident system had become well established and was operating smoothly; also, the sulfonamides were in general use and were employed as indicated in table 1.

The primary object of the investigation was a study of the methods of treatment, the records kept and the results as indicated by the mortality, morbidity and length of the period of hospitalization. In addition, any information was sought that might be helpful in promoting better care of cases of appendicitis in the future.

In all cases of the series a diagnosis of appendicitis or its complications was made at the time the patient was admitted. In those cases classified as pelvic infections, there was simply a mistaken diagnosis. In this group the appendectomy was not incidental to some other operation.

In the first column of table 1 the total number of cases studied under each classification is enumerated. In no group presented is there overlapping of cases. The fact that one case of acute appendicitis terminated fatally each year, as recorded in the second column, is not unusual be-

cause in this group are included all the cases up to actual gangrene or rupture. In the case observed in 1941-1942 the patient had apparently recovered and was out of bed on the ninth post-operative day when a pulmonary embolism occurred.

The statistics in this second column are remarkable only in regard to the group of cases of ruptured appendix. The percentage of mortality in this group offers no conclusive proof because too many variable factors existed. At least half of the patients, and probably more, had had from one to four laxatives. When castor oil failed to produce results, salts, usually not well retained, and then black draft were tried. Many of the patients of this group were moribund when they entered the hospital, but since one cannot refuse to admit a patient merely because he is a poor surgical risk, neither can one rule his case out of a review of the cases observed. All surgeons would prefer to choose the cases on which surgical mortality is to be judged, but it seems as illogical to do so as to refuse a person the benefit of surgery when it offers him his only chance.

To justify the use of the present resident system was one important object of this study. Unless the information contained in the next two columns accomplishes this end, this purpose may well be forgotten. The mortality rate, indicated by the figures in the third column, does not help the cause. If, however, one considers that this hospital deals 100 per cent with charity patients, he realizes that the mortality is likely to fluctuate with the class of patients treated. In times of depression many persons of a relatively high degree of intelligence are reduced through sheer stress of circumstances to the necessity of accepting charity treatment whereas in good years most of the patients in a charity hospital are of a considerably lower degree of mentality and thus are more likely to have taken laxatives or to have waited very late to enter the hospital.

As shown in the fourth column, the average number of hospital days was reduced in almost every instance in both of the years in which the resident system was in use. This reduction was due in part to the fact that during these years it was unnecessary to wait for a busy surgeon to leave his practice and come to the hospital to operate. The house staff merely telephoned him and if he was unable to come, they were authorized to proceed with the operation.

As has been illustrated in foregoing paragraphs, figures can be made to prove anything that is desired. While the figures for the first three groups of cases in table 1 can be depended upon, those under the next three, pertaining to ruptured and gangrenous appendixes and to appendical abscesses, are valueless. For example, the record of 1 or 2 patients who died twenty-four hours after admission would materially reduce the average number of hospital days. Likewise, the average number of postoperative days would also be reduced. As it was, the average number of postoperative days, shown in the fifth column, was reduced during the last two years partly because patients were discharged by the house staff as soon as they were considered able to leave instead of being required to wait for regular ward rounds.

Through the years many aids to surgery have been devised, and many drugs have been hailed as the panacea for all human ills. The sulfonamides have had the spotlight for the last few years. Many clinics have reported remarkable results, and a few have claimed almost 100 per cent cures following the use of these drugs. The policy laid down by the Chief of the Department of Surgery of the Duval County Hospital is dependence entirely upon good surgical principles, judgment and technic, and then exploitation to the utmost of any other aids which may be available. In keeping with this policy, during the third year studied, as shown in the sixth column, the sulfonamides were used in most of the particularly bad cases including all the cases of ruptured appendix. It may be seen from the statistics presented (tables 1 and 2) that their use did not affect the mortality favorably, but it may have helped somewhat with the morbidity as reflected in the length of the postoperative period of hospitalization. I do not wish to minimize the value of the sulfonamides and certainly have no desire to be without them again in the practice of surgery, but the results in this small series of cases appear to justify the stressing of good surgery first and surgical aids, whether new or old, second.

This review of 292 cases illustrates the difficulty of obtaining facts of statistical value from average records. To get figures which represent facts, one would need to plan far ahead what facts he wished to establish. With the nature of the desired information determined in advance, all records could be made to include ac-

TABLE 1

Classification	Total Number of Patients	Deaths	Mortality Rate in Per Cent	Average Number Hospital Days	Average Number Postoperative Days	Sulfonamide Used in Per Cent
Acute Appendix	1936-37	32	1	3.12	16.50	14.60
	1938-39	64	1	1.56	11.90	10.71
	1941-42	50	1	2.00	11.27	10.19
Subacute Appendix	1936-37	7		13.00	10.30	
	1938-39	14		9.71	8.33	
	1941-42	11		10.72	8.60	27.30
Chronic Appendix	1936-37	9		14.00	10.75	
	1938-39	12		13.16	10.00	
	1941-42	4		13.25	9.75	25.00
Ruptured Appendix	1936-37	12	3	25.00	27.00	27.90
	1938-39	9	4	44.44	22.22	27.14
	1941-42	22	8	36.36	15.09	14.00
Appendical Abscess	1936-37	2		32.00	28.50	
	1938-39	4		33.75	67.00	
	1941-42	9		14.77	17.50	44.44
Gangrenous Appendix	1936-37	4		19.25	18.00	
	1938-39	4	1	25.00	16.50	15.50
	1941-42	5		11.20	10.00	40.00
Normal Appendix	1936-37	2		12.50	11.50	
	1938-39	5		9.20	9.00	
	1941-42	4		9.75	8.00	50.00
Mesenteric Adenitis	1936-37					
	1938-39					
	1941-42	3		11.33	8.00	
Pelvic Inflammatory Disease	1936-37	1		18.00	11.00	
	1938-39	1		34.00	29.00	
	1941-42	2		10.50	9.50	100.00

curate data, and these data could be so organized that review of them later would leave no doubt as to their meaning. For example, an attempt was made to determine the number of patients who had taken one or more laxatives, but on many records no mention was made of this detail. It is probable that these patients had not had a laxative, but the assumption could not be made for the purposes of this survey.

TABLE 2

Year	Over-all Mortality in Per Cent	Total Number of Cases
1936-1937	6.06	69
1938-1939	5.60	113
1941-1942	7.92	110

The greatest benefit that has or will come from this review is the improvement the surgical staff is able to make from having learned the weaknesses of its methods. One good example is the shift in responsibility for recording the history and the results of the physical examination in emergency operative cases. Instead of having a physician write these records simply because he is on the surgical service, the physician who sees and helps with the operation now writes them.

#### CONCLUSION

A survey of 292 cases of appendicitis observed under varying conditions at the Duval County

Hospital failed to establish the expected results. It brought to light, however, a few weak points in the system of records. Also, it satisfied the surgical staff that the use of the resident system reduced the period of hospitalization in these cases and enabled the patients to receive more prompt attention and thus better treatment. The results of the use of the sulfonamides are of interest, but in this small and uncontrolled series they offer no conclusive proof of value.

#### Duval County Hospital.



#### REFRIGERATION FOR SKIN GRAFTING

Anesthesia by refrigeration of the areas from which skin is taken for grafting purposes is recommended "because it is simple, time saving and efficient," Lieutenant Harry E. Mock Jr., Medical Corps, United States Army, declares in *The Journal of the American Medical Association* for June 26.

"Refrigeration anesthesia for skin grafting opens a new field for the use of reduced temperatures in surgery," Lieutenant Mock says. Two hours before operation, one or more uncovered ice bags are applied directly to the area from which the skin is to be taken.

## EMERGENCY MEDICAL MANAGEMENT IN GREAT BRITAIN

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MIAMI

I have been requested to speak to the members of the Dade County Office of Civilian Defense regarding the manner in which war casualties are handled by civilian defense workers in Great Britain. I have tried to select those topics of information which may enhance the knowledge you have already acquired, and I shall stress the differences in methods employed under actual bombing conditions.

As you may know, the Emergency Medical Service in Britain corresponds to our Office of Civilian Defense. The organization of that service parallels our own, particularly as regards casualty stations and first aid posts. Because, however, of the imminent danger of possible invasion by the enemy, the British also have three other services concerned with casualties with stations of their own, namely, the Air Raid Patrol, the Home Guard and the Royal Army Medical Corps.

The Emergency Medical Service is directed by full time salaried medical officers. War is a serious matter in which there is no place for halfway measures. The Service has also established general and overflow emergency hospitals, many of them underground, mobile medical units composed of specialists in certain types of injuries, convalescent and rehabilitation homes for casualties, and housing for the bombed out. Compensation is paid to workers who are disabled. Volunteer workers are taught by experienced medical officers of the service and R. A. M. C. Civilian physicians are paid for their services, but are compelled to attend special courses on war injuries.

In the city of London, certain hospitals have been designated as centers for the care of particular types of injuries, and mobile medical units are on call to treat the casualty locally. These hospitals and units are classified as treating, for example, injuries of the head, or chest, or abdomen.

Three years' experience with war casualties due to air raids has resulted in many radical changes in first aid methods. Most casualties require immediate hospitalization. First aid

management as practiced in peace time has proved useless in time of war. The methods are too elaborate and time-consuming. Authorities believe that too much has been taught in the name of first aid and that it is much wiser to teach the greatest number of people the simplest facts of common sense that save life. There is no longer such a subject as advanced first aid.

In Great Britain, experience has shown that one third of all casualties in an air raid will have multiple major injuries and that most of them will die soon after the raid, which is generally of nightly occurrence. About 50 per cent of the injuries in this group are caused by the falling debris of collapsing buildings. Another third will have injuries to the lower extremities, particularly those persons who happened to be standing during the raid, as the bomb explosion emits a nearly horizontal fan of fragments. The majority of all casualties are usually in serious enough condition for immediate transportation from the scene of disaster to hospitals. Great destruction is caused by the heavier high explosive bombs and land mines, which are up to 4 tons in weight.

In England, casualty stations are known as casualty collection posts. They are most useful as collection centers for the classification and segregation of injuries by type, extent and severity. They serve chiefly as clearing houses for the distribution and transportation of casualties to hospitals.

To keep the health of the public at a high level and to increase resistance to infection and to the rigors and deprivations of warfare, health officials have inaugurated a program of immunization against preventable diseases. The incidence of all diseases is greatly increased in time of war, particularly those of a contagious nature. Malnutrition is common due to limited food supplies. The rationing of fuel and clothing frequently results in overexposure to the elements and brings about lowered general resistance to infection. The spread of disease is encouraged by overcrowded public shelters, lack of fresh air and sunshine during continuous air raids, and poor sanitation. Nevertheless, despite these unfavorable conditions, it is amazing to learn that the health of the general public in England has withstood the ravages of warfare remarkably well.

Medical Supervisor, District 4, O.C.D., Miami.  
Read before the Dade County Office of Civilian Defense  
at the Central School, Miami, Nov. 17, 1942 and to Division  
10 at the Buena Vista School, Dec. 14, 1942.

Civilian defense workers are expected to set a high example in their community and to help educate the people as regards the importance of public health matters. The civilian worker must be highly trained so that he can carry out his duties under such adverse conditions as are created by the explosion of delayed action bombs, fires caused by incendiary bombs, flying glass and masonry, falling buildings, and the thick blanket of smoke and dust which hovers over the scene of disaster for hours.

In Great Britain, the Red Cross has been convinced that red tape must be cut in the procurement of medical equipment. Apparently, it took much persuasion before local authorities saw fit to obtain necessary supplies. It is now evident, however, that supplies are of no value in central depots, but must be stored in the casualty stations themselves. The stations are at present supplied with those items which have proved most useful. Triangular bandages have been the most valuable, although great use has been made of the T bandage and 3 inch rolled bandage, vaseline gauze strips and sterile dressings 4 by 4 inches in size. Clothing must be available as many casualties are soaking wet, or their clothes are soiled with blood, grease and grime, or torn to shreds. A supply of pajamas, bed gowns, socks, many blankets and pneumonia jackets is on hand. Nourishment in the form of coffee, tea, soups and other canned foods is also available. There is still great need for more beds, cots, mattresses and sheets. For emergency lighting, hurricane lamps are employed, but candles are also stored. On the walls there are tacked printed cards of instruction in first aid.

Casualty stations generally are strategically located and easily accessible. Underground floors of public buildings are preferred, but frequently, particularly in rural districts, stations have been set up in barns, or private homes. Much effort has been expended to protect the station from damage by bombs. A few sandbags and a couple of nailed boards have proved of no value against the blast effect of demolition bombs. Plans have been made in advance as to casualty evacuation in the event of invasion by the enemy. Routes of evacuation and substitute stations have been mapped. Casualty stations are located at or near all hospitals, and at distances more than 1 mile from a hospital, for the care of minor casualties which do not require hospitalization.

The staff usually consists of two doctors, several nurses and a variable number of nurses' aides and auxiliaries. In a large city, such as London, casualty stations are situated about one mile apart with a ratio of about one station for 25,000 inhabitants. In the smaller communities, however, the stations are more numerous in proportion to the population.

Upon receiving a report from an air raid warden that a bombing incident has occurred and that there are approximately so many casualties, the local control center immediately dispatches an express party to the scene of the disaster. The express party includes one rescue first aid unit, one ambulance, one sitting case car and one mobile medical team. This team consists of one physician, one nurse and two auxiliaries. No other equipment or personnel of the emergency medical service is sent unless additional assistance is requested by the incidence officer, usually a higher police official, or by the incidence physician on the scene. In this manner useless movement is avoided, and equipment and personnel are carefully conserved.

The presence of a physician at the scene is invaluable, but more than one is necessary. One physician may cover several nearby incidents, leaving his nurse or one of the nursing auxiliaries of his emergency team at the original scene while he moves temporarily from one place to another in the immediate neighborhood.

In the large cities the field casualty service may handle from two thousand to three thousand, five hundred casualties during a night raid. All serious casualties are moved to hospitals, but not to casualty stations. Heavy raids are apt to be repeated on subsequent nights when the protective forces are exhausted. Even though a single night's casualties requiring hospitalization may total one or two thousand, each of the large hospitals rarely receives more than from 50 to 100 patients, the load being distributed as evenly as possible throughout the city hospitals and the related peripheral hospitals in the suburbs.

To accomplish the tremendous task of transporting large numbers of casualties to the hospitals, a large fleet of four stretcher ambulances is essential. Fourteen thousand ambulances were made in England and Scotland by purchasing used cars, stripping them and mounting a simple ambulance body on the chassis. London uses over fifteen hundred such ambulances and five

hundred and fifty sitting case cars. The use of tradesmen's trucks proved universally unsatisfactory; three out of four never arrived on the scene, and lives were lost as a result of the delay and confusion. Because of the large number of casualties to be transported within a few hours, no ambulances which carry less than four stretchers are employed. For the simultaneous evacuation of damaged hospitals, a fleet of two hundred converted busses, each carrying 10 stretcher cases and from 6 to 10 sitting cases is immediately available, and another two hundred are obtainable within two hours.

Although the commonest injuries as a result of air raids consist of burns and fractures, in the larger cities injuries due to flying glass and masonry have been of frequent occurrence. The blast of a demolition bomb will litter a street with glass, ankle-deep. Jagged fragments of plate glass from shop windows have been hurled with such fury that they have penetrated partitions and walls with ease. Glass is considered the most dangerous fifth columnist that a man can harbor in his home during a raid.

In the field, first aiders have been taught to practice only the simplest first aid measures. Casualties are handled very gently. They are made as comfortable as possible with a minimum of movement. Shifting a victim from place to place or from stretcher to stretcher is avoided. Hurried or unexpected handling opens wounds, restarts pain, jars fractures and intensifies shock. A rapid estimate is made of the nature of the injury, its extent and severity. Attention is given to placing the casualty in the proper position. Stretcher bearers must learn to carry casualties in the prone or semiprone position in cases in which the patient has breathing difficulty due to wounds of the face, in order to prevent the tongue from falling back. Hemorrhage from a facial wound can be controlled by keeping the tongue forward. In wounds of the chest or abdomen, the victim is placed in a half sitting position. If pain is severe, a tablet of morphine for oral administration is put under the victim's tongue. If necessary, the dose is repeated in half an hour, but no further dose is administered for the next four hours. The amount of the dose and the time it was given are entered on the casualty's identification tag.

In the treatment of wounds at the scene of disaster, first, hemorrhage is controlled by firm pressure with a dry sterile dressing. This method

is usually effective. If necessary, finger pressure is employed over the main artery to that part. The use of a tourniquet is frowned upon. Too often, it has been the cause of gangrene and amputation. If nothing else will stop the bleeding, it may be used, but pressure must be released at least once every fifteen minutes.

Wounds are usually grossly contaminated; and grease, grime and blood have been driven deeply into the skin and injured parts, giving a ghastly appearance to even a slight wound. No amount of cleansing by first aiders can decontaminate the wound sufficiently to avoid sepsis. Small puncture wounds of the skin often are deceiving as they may conceal extensive injuries to vital internal structures caused by minute particles of high speed shrapnel. Frequently the small neat wound is worse than the large bloody one.

Each scalp wound is explored by the medical officer to determine if any damage to the brain has been incurred. In the handling of wounds, after hemorrhage has been controlled, sulfanilamide is powdered freely upon the raw surface. Then a dry sterile dressing is applied, and the wound is bandaged.

In severe wounds of the extremities, the limbs are immobilized by splinting in the same manner as is done for fractures. Severe abdominal wounds usually present a hopeless condition.

In the first aid treatment of fractures, the rule, "splint them where they lie," applies. In the case of a fracture in an extremity, the limb is placed in the most natural position. A broken limb is not allowed to flap. If an arm is broken, it is bound to the chest firmly. If a leg is fractured, it is splinted by tying it to the other limb, foot to foot, knee to knee, and thigh to thigh. Use is made of any available means to immobilize the fractured parts, such as the victim's belt, shoe laces, suspenders, garters and handkerchief. A fence picket, baseball bat, golf club, rifle, blanket or sandbag is often used as a splint. Traction splints are used only when a casualty must be transported over long distances on rough roads. In a compound fracture, the usual treatment is applied to the wound. In England each hospital has a fracture service, and also a burn department.

The first aid management of burns depends to a large extent upon the degree and location of the injury. First aid treatment must not com-

promise later hospital care. Coagulants, such as tannic acid, are not used on major burns. A coagulant applied to an unclean surface walls off bacteria and leads to infection and destruction of already devitalized tissue. Once it is applied, the crust that forms is difficult to remove, thereby obstructing satisfactory surgical treatment. The crust tends to contract on drying and so produces dangerous constriction of blood vessels. Consequently, tannic acid is not applied to third degree burns nor upon any area of functional importance, such as encircling burns of the hands and feet and burns of the face, flexures, perineum, or genitalia. Tannic acid ignites in the presence of phosphorus when applied to burns caused by phosphorus-oil bombs.

In minor burns and in extensive first or second degree burns of the trunk and proximal parts of the limbs where shock and toxemia frequently develop, tannic acid is of value as it soothes and makes the victim more comfortable. Lately, a wax, known as ambrine and having antiseptic as well as coagulant properties, has replaced tannic acid jelly. When jelly is employed in the treatment of burns, no dressing is applied.

First aiders have been trained to distinguish between minor and major burns which require immediate hospitalization. For minor burns, the following procedures are recommended by the E. M. S.: (1) Sprinkle powdered sulfanilamide freely upon the burnt area. (2) Cover the burn with strips of sterile vaseline gauze. (3) Cover with a layer of absorbent cotton. (4) Apply a bandage. If the casualty is treated in the station, it is preferable to cleanse the burn and surrounding skin with soap and water, using soap flakes.

Sterile vaseline gauze is made in the following manner: A one-half gallon can is half filled with vaseline and is heated to the boiling point in a basin of water. When the vaseline is melted, strips of gauze about 6 inches square and folded in two are dropped into the can until it is full. More vaseline is added to keep the gauze covered. The can is left in boiling water for one-half hour. Then it is removed, covered firmly and sealed with adhesive tape. It is stored for future use.

If there is delay in the transportation of the patient with a major burn to the hospital, the burn is exposed part by part to avoid shock and is dusted with sulfanilamide; then the area is covered with a sterile towel or a wet saline com-

press. An oilskin envelope will keep the compress moist during transportation and will prevent the danger of infection by flies. When transportation is delayed for days, coagulants must be employed for the patient's comfort, even though undesirable. All cases of severe burns likely to be followed by loss of function or disfigurement require extensive skin grafting.

The most difficult cases handled by first aiders are those of shock. This is also the problem that arises in the case in which there are serious burns and major wounds. The local treatment of the burn is of secondary importance except under unusual circumstances, and consists of protecting it from further damage and secondary infection. With shock, each moment that passes before plasma or serum transfusion is given increases the risk to the casualty's life. Shock is increased by the loss of body heat; therefore, exposure of a small area of the burned part for treatment before dealing with the next part, minimizes this loss.

Primary shock is not commonly observed. It resembles a fainting attack and usually passes off quickly under the influence of rest, heat and morphine. True burn shock is the secondary stage of shock and is similar to wound shock. The pulse rate rises, and the pulse becomes feeble and thready; the respiration rate increases; the victim becomes very pale and then ashy grey in color; he is anxious, apprehensive, nervous and restless; his blood pressure keeps falling. Secondary shock is always considered a serious complication and is responsible for 60 per cent of all deaths from burns. It may appear within one hour of the injury, but generally not for six hours or more. Usually during this time, the victim looks well and feels well, and he may even walk several miles to a casualty station with burns of the severest type. It is best to transport this casualty to a hospital during the time that he feels well. Once shock develops, transportation becomes fraught with danger to the victim's life.

The extent and location of the burn is an indication of the likelihood of shock developing. In general, shock is liable to be more serious if more than 25 per cent of the surface of the body is burned. Burns of the face, front of chest and abdomen are more dangerous than those of the arms, legs, or back. The depth of the burn is not as important as regards shock as is its extent.

To reduce the degree of shock in extensive burns, pain should be alleviated by full doses of morphine, repeated whenever necessary. If shock exists, the casualty with the severest burn is not conscious of pain until the shock passes off. If shock occurs prior to transportation, make the patient lie on the stretcher and place blankets under as well as over him; if possible, put a hot water bottle or hot brick covered with flannel at his feet, and elevate the foot of the stretcher. Give him liquids freely, especially hot sweetened drinks, and call for the medical officer so that immediate blood transfusion may be arranged.

The treatment for shock due to wounds is similar to that due to burns. At the casualty station patients suffering from shock should be placed in cots or beds with the foot elevated on blocks from 12 to 18 inches high. Fluids may be given except to patients with abdominal wounds, and  $\frac{1}{2}$  teaspoonful of common salt should be added to every pint of liquid administered to help the tissues retain fluids. Shock is considered due to loss of fluids as well as loss of body heat.

As a result of modern bombing raids, two new types of injury have been recognized among the casualties; blast concussion and compression casualties. In blast concussion the extreme pressure and suction effect of demolition bombs affects the lung and causes internal injuries to that organ without there being any external wound. The casualty is very pale, cyanotic and dyspneic; his chest bulges become fixed in a position of three-fourths inspiration. It is a serious condition and must be recognized. The treatment is the same as for shock. The condition is accompanied by severe pain in the chest which requires sedation with morphine. Difficulty in breathing is an indication for oxygen therapy. The victim should not be moved any more than is necessary.

Compression or crush injury occurs in those casualties who have been pinned for some time under the debris of collapsed buildings, particularly where the legs have been compressed. Frequently, there is no external sign of injury, but due to damage of the muscles and obstruction of the circulation in the limbs, toxemia develops. The victims pass quickly into shock. Fluid must be given very cautiously in these cases as the kidneys are often affected and its administration may increase the degree of shock.

At the British casualty station casualties are given tetanus antitoxin, and if muscles have

been damaged, antigas gangrene serum is administered as well. It is also advisable to begin sulfanilamide treatment by mouth at the station.

Artificial respiration has proved to be of little value for war casualties, except in cases of drowning or asphyxiation. Since it is almost impossible to determine in a particular case the presence of extensive internal injuries, such as fractured ribs or ruptured vital organs, a decision as to whether artificial respiration is indicated or dangerous can be reached only by a medical officer. When difficulty in breathing is caused by shock or toxemia, artificial respiration will not resuscitate the victim; instead, it may increase the degree of shock.

You are all familiar with the report issued by Dr. Baehr of the Office of Civilian Defense in Bulletin 31. It includes the following statement:

In England first aid parties (our stretcher teams) are not necessary; are a waste of manpower and are rapidly being eliminated. First aid at incidents is essentially a function of the rescue parties (our rescue teams), which extricate the casualties from under the debris of demolished buildings. All first aid parties in England and Scotland are therefore being merged into the rescue parties. They include a leader, an assistant leader and eight other members, and are entirely independent of the fire department. They are a life saving service related to the medical services concerned in field casualty work.

My information regarding first aid management as carried out in Great Britain has been gleaned from British medical journals and personal correspondence. I hope that it has not created too much confusion in your minds or dissatisfaction in regard to the value of our own first aid training. Our training in first aid is of high caliber, ideally suited to peace time civilian casualties, particularly those due to natural disasters.

Should an emergency arise, common sense will tell us how much of our present knowledge of first aid can be of practical application in solving the problems of war casualties. We lack the experience of those who have been under actual fire, but it does not require experience to appreciate the fact that first aid saves lives and stops panic. We realize that calming a wounded man, treating him like a child if necessary, is first aid in its practical application. We know that a man bleeds to death very quickly, that we must stop the bleeding even with our hands if nothing else is available and that there may not even be time to wash. That, too, is first aid. It is also common sense!

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## TIME LIMIT SET FOR REGISTERING MEDICAL LICENSES

Licenses to practice medicine in Florida must henceforth be registered within sixty days of the date shown on the license. All unregistered licenses which were in effect on June 11, 1943, must be recorded within six months of that date.

These provisions were contained in Senate Bill No. 641, amending section 458.06 of the Florida Statutes of 1941, which became law on June 11, 1943.

The original law required that every license to practice medicine be registered in the office of the clerk of the circuit court of the county in which the licensee resides or in which his practice is intended to be carried on. No limit of time was specified for such registration, however, which proved to be a serious omission. Licenses have been recorded as late as twenty years after date of issuance. The framers of the original act undoubtedly intended licenses to be registered promptly, but lack of a specific provision in this respect left the door open to the recording of fraudulent licenses issued many years before. It has been extremely difficult to prove the fraudulence of some of these old unrecorded licenses.

In 1927 an act was passed requiring physicians to register annually with the State Board of Health. Before becoming eligible for this annual registration, a physician is required to show proof that his license has been recorded with the clerk of a circuit court. This act did not shut the door to fraudulence, however, as a license dated twenty years back could at any time be thus recorded, making the applicant eligible for registration with the State Board of Health.

The new amendment has strengthened the medical practice act. By requiring the prompt recording of all medical licenses, it should close the door to the use of fraudulent licenses. This amendment reads in part as follows:

The Clerk of the Circuit Court shall not accept for recording, and shall not record any such license to practice medicine, dated after the effective date of this act, unless the same shall be presented to him for recording on or before the expiration of sixty days after the date of such license, or the date of the re-certification thereof by the Board of Medical Examiners; Provided further that no license to practice medicine dated prior to the effective date of this Act may be recorded by the Clerk of the Circuit Court unless the same shall be presented to him for recording on or before the expiration of six months from and after the effective date of this Act, or within sixty days after the date of re-certification thereof by the Board of Medical Examiners.



## REPORT OF FLORIDA DELEGATES TO A. M. A. HOUSE OF DELEGATES

MEREDITH MALLORY, M. D., ORLANDO  
EDWARD JELKS, M. D., JACKSONVILLE

### To the Members of the Board of Governors:

The 1943 session of the House of Delegates of the American Medical Association convened in the Palmer House, Chicago, Illinois, Monday, June 7, 1943, at 10 a. m.

The first order of business was the voting for the recipient of the Distinguished Service Award. The Board of Trustees presented three names: Dr. A. J. Carlson, Dr. E. P. Joslin and Dr. Torald Sollman. Dr. E. P. Joslin received the majority of the votes of the House.

Dr. H. H. Shoulders, speaker of the House, delivered his address in which he told of the responsibilities of each member of the House in the past, the present and in the future. He asked that all be statesmen and not politicians, that the future of our profession might be guided along the right paths. He felt that the future of medicine lay in the statesmanship of its officers rather than in research.

The president, Brigadier General Fred W. Rankin, delivered the presidential address. He brought out the fact that the medical profession is living up to its reputation of the past by giving the armed forces the best care they have ever had; the increased industrial demands have been met, and so far the civilian population has not suffered. The rapid mobilization has been consummated and we are about to enter into the main part of our job.

Influences are at work to effect epochal changes in the practice of medicine and the war has brought them to the front. Postwar planning shows quite definitely the socio-conscious trend which assures "adequate medical and health care regardless of place of residence or income status." It is our duty to participate in these changes; instead of trying to hinder them, we should try to guide them, that the profession will not suffer. The establishment of some contemplated medical service does not mean the end of private practice. Also we must be ready to meet the postwar rehabilitation of physicians whose return to civilian status will necessitate readjustment.

He urged that suitable agencies be set up in the Association to consider all of these problems and be ready to collaborate with the government and the public.

President-elect Dr. James E. Paullin then delivered his address. He spoke of the different officers, councils and committees that had been functioning in the prewar days and since war was declared, also the necessity of the training of those physicians who have entered the service, that they might return to civilian life. The future of medical care will be a great problem and one that will tax the leadership of American medicine.

Major General Norman T. Kirk, recently appointed

Surgeon General of the Army, gave a short talk and emphasized the fine work rendered by the medical profession in the Tunisian campaign. He spoke briefly of some of the incidents of that campaign and the low mortality rates.

Mr. George M. Morris, president of the American Bar Association, made a short address, complimenting us upon our organization, the way it is conducted, and how the Bar Association had patterned its House after ours.

Dr. T. C. Routley, secretary of the Canadian Medical Association, was presented and said a few words.

Next, the report of the secretary was presented, followed by the report of the Board of Trustees, which included a supplementary report taking up the question of the practice of medicine by hospitals and the relation of radiologists and other laboratory facilities.

Various resolutions were presented, several having to do with medical service and better facilities to be established in Washington.

It was voted to keep the House in session until business was finished, rather than wait until the fourth day for the election of officers, as is customary when the whole Association is in convention.

The attendance was excellent, every state being represented by full delegation. Each section was represented, as was the Army, Navy and Public Health Service. The only absentees were those from the Philippine Islands, Alaska, Panama and Puerto Rico.

The resolution to discontinue the representatives in the House from the different sections was voted down.

Considerable debate was entered into relative to the resolution dealing with medical service and the establishment of an office in Washington. Finally it was decided to create a council on medical service and public relations.

Per custom, the House was reapportioned on the basis of a delegate to every 965 members. This does not have any bearing on Florida.

Again Florida was represented on one of the reference committees.

The following officers were elected:

Dr. Herman L. Kretschmer, Chicago—President-elect.

Dr. John W. Amesse, Denver—Vice President.

Dr. Olin West, Chicago—Secretary.

Dr. J. J. Moore, Chicago—Treasurer.

Dr. H. H. Shoulders, Nashville—Speaker, House of Delegates.

Dr. R. W. Fouts, Omaha—Vice Speaker.

Dr. William F. Braasch, Rochester, Minn.—Trustee.

Dr. Ernest E. Irons, Chicago—Trustee.

San Francisco was selected as the 1946 meeting place.

Meredith Mallory,

Edward Jelks.



## RECENT AMENDMENTS TO FOOD RATIONING MEET NEW NEEDS

Recent amendments to food rationing orders, involving osteopaths, condensed milk, fats, oils and hospitals, are summarized in The Journal of the American Medical Association for July 17 as follows:

The Office of Price Administration announced on July 2 that any medical practitioner authorized by the state in which he practices to prescribe all internal drugs is also authorized to certify that a person requires supplementary food rations for health reasons. Authority to make such certification was previously confined to doctors of medicine. OPA has now broadened the authority so that osteopaths in states which license osteopaths to prescribe all internal drugs may also prescribe supplementary food rations. Food rationing regulations provide that a person whose health requires more rationed food than his ration points permit him to buy may apply to his local board for necessary additional points. In some

illnesses foods are prescribed in addition to drugs or medicines, or as a substitute for them. In some counties the work of ration boards in processing such applications has been much simplified through the voluntary help of the doctors themselves. By establishing panels to review all medical certifications and to advise the boards, responsibility for issuing extra rations for health reasons has been kept on a professional level.

The Office of Price Administration under date of June 1 placed evaporated and condensed milk on the list of rationed products. These types of milk are added to the group of rationed foods containing meats and fats, for which red ration stamps are needed, without any increase in the total number of points allowed for this group. One point is required for one 14½ ounce can or for two 6 ounce cans or for two 8 ounce cans. This means that the child may use 7 of his 16 points per week for his milk requirements in terms of evaporated milk, which allows slightly less than the equivalent of a quart of whole milk per day, and have 9 points remaining for his meat and fat requirements. An invalid or any other person whose health requires that he have more canned milk than he can obtain with the stamps in his War Ration Book II may apply at his local War Price and Rationing Board for additional points. The consumer must submit a written statement of a licensed physician showing why he must have more canned milk, the amount needed during the succeeding two months and why unrationed foods cannot be used instead. A supplemental allotment to acquire canned evaporated and condensed milk needed by a hospital to meet the dietary needs of its patients may be obtained on application to its local War Price and Rationing Board. It is understood that, if the present method of rationing does not make evaporated milk available in all areas for infants and children, some more effective method will be worked out.

The Office of Price Administration has issued an amendment to ration order number 16 (R. O. 16, amendment 25) which permits the use of rationed fats and oils for external therapeutic purposes. This includes the use of vegetable oils, such as cottonseed oil, for bathing newborn infants, for external application in skin diseases, for urethral injection or lubrication of urethral instruments, and for x-ray visualization. Such use of rationed fats and oils is defined as "industrial consumption" and persons using these products for such purposes are classified as "industrial consumers." An industrial consumer engaged in the care and treatment of the sick and needing rationed fats and oils for this purpose may apply to his district Office of Price Administration for a certificate with which to acquire them. The procedure to be followed, briefly, is as follows: The application should be made on form R-1605 to the district office. If the applicant is a hospital the district office will pass on the application by using the same method of computing allowances as the local boards use in computing allotments for industrial users; otherwise the application will be forwarded to the Washington office for action. If the applicant requires more than he would receive by the method of computation described, he should also submit form R-315 stating the reasons for such request. An "industrial consumer" to whom a certificate is issued for "industrial consumption" of rationed fats and oils may use it only to acquire the foods for which application was made and may use those foods only for the purpose for which the application was granted.

For several months the Office of Price Administration and medical authorities have been studying the hospital problem with a view to developing a uniform procedure covering the granting of supplemental allotments for hospitals. Solution of the problem is believed near. In the meantime a provision in the regulations (section 11.6 of general ration order 5) should enable hospitals to obtain the necessary supplemental allotments so that patients need not suffer from dietary deficiency. This provision gives local boards authority to grant such allotments to meet the dietary requirements of patients living in and receiving care in hospitals whether or not such patients are

on special diets. In determining the amount of the supplemental allotment of processed foods and the commodities covered by ration order 16, the local board will take into consideration the availability of fresh fruits and vegetables, unrationed substitutions such as poultry and fresh fish, and the physical facilities of hospitals to process and store such foods.

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

Dr. and Mrs. R. D. Ferguson of Ocala announce the birth of a son, James Glese, on June 13.

Dr. and Mrs. Archibald F. Caraway of Jacksonville announce the birth of a son, James Spence, on July 30.

### MARRIAGES

Dr. Warren H. Sears of Winter Park and Miss Anne Holcomb Bethune of Miami were married on July 1.

### DEATHS

Dr. Thomas M. Rivers of Kissimmee died on July 27.

## STATE NEWS ITEMS

Dr. Thomas E. Cato was appointed director of the health unit in Dade County in May to succeed Dr. Thomas H. D. Griffitts.

Dr. Eugene G. Peek of Ocala, president of the Florida Medical Association, was the guest speaker at a meeting of the local Rotary Club held in July. Dr. Peek's subject was preventive medicine.

Recent visitors at the Association's headquarters in Jacksonville were Dr. Eugene G. Peek of Ocala, president, Dr. Walter C. Jones of Miami and Dr. Leigh F. Robinson of Ft. Lauderdale, all of whom are members of the Association's Board of Governors.

Dr. Henry B. Oertel, formerly of Orlando, has joined the staff of the Florida State Hospital.

Dr. Charles E. Creel of Pahokee spent July in Boston where he took a course in modern diagnosis and treatment of heart disease, under Dr. Samuel Levine.

Members of the Association who attended the Southern Pediatric Seminar, held in July in Saluda, N. C., were: Drs. W. C. Page, Cocoa; K. K. Waering, Jacksonville; J. P. Tomlinson, Lake Wales; M. B. O'Kelley, Leesburg, and W. W. McKibben, Miami.

Dr. Sidney Halpern of Jacksonville announces that his new offices are located in the Professional Building.

Dr. William D. Lithgow of Miami visited a number of clinics while on his vacation in August. A part of his time was spent at Collegeville, Pa. with his nephew.

## JULIAN FORREST GARDNER

Dr. Julian F. Gardner, city physician for Winter Park and for Rollins College for the last six years, died at an Orlando hospital on June 19. He would have been 75 years old on July 19.

One of Winter Park's most beloved citizens, Dr. Gardner had made his home there for the past nineteen years. A practicing physician for fifty-three years, he was a native of Oglethorpe, Ga. After receiving his early education in the public schools of Georgia, he entered the University of Louisville School of Medicine, from which he was graduated in 1890.

Dr. Gardner was known to residents of Winter Park as a fine physician and a great humanitarian. Last year he was presented the Algernon Sydney Sullivan award at the Rollins College convocation.

Surviving, besides his widow, Mrs. Mamie Gardner, are a daughter, Mrs. J. R. Hogg of Barboursville, W. Va., and a brother, George Gardner of Oglethorpe, Ga.

Dr. Gardner was a member of the Orange County Medical Society, the Florida Medical Association and the American Medical Association. He was also a member of the Kiwanis Club and the Chamber of Commerce.

## BURTON THOMAS GORDON

Dr. Burton T. Gordon died suddenly at his temporary home at Deerfield Beach on July 2, at the age of 58.

Dr. Gordon was born May 14, 1885, at Scottville, Michigan. He received his A.B. degree at the University of Michigan, and his medical degree at Rush Medical College. He served his internship at the House of Correction Hospital in Chicago. From 1911 to 1914 he was examiner for the International Harvester Company and then entered private practice. In 1925 he took a special course in ophthalmology and otorhinolaryngology at the University of Vienna, Austria. Returning to Chicago, he practiced his specialty until in 1925 when he came to Florida because of ill health. He had been told he had but a few months to live.

Within a year Dr. Gordon had recuperated and opened an office at Pompano, where he practiced until the day of his death. His civic interest soon made him one of Pompano's leading citizens. He recently purchased and began remodeling the Alamo building in that city.

Dr. Gordon was married April 14, 1909 to Miss Mary Spengler of Archbold, Ohio. She survives him, as do one son, Lt. Marion Lee Gordon, who is with the Army Medical Corps in Texas; two daughters, Mrs. Frances Tulin and Mrs. Margaret May, both of Chicago; his mother, Mrs. Hester Gordon of Pompano, and two sisters, Mrs. John Engleman of Detroit and Mrs. Grace Hawley of Ludington, Mich.

Dr. Gordon was a member of the Broward County Medical Society, the Florida Medical Association, and a Fellow of the American Medical Association. He was a member of Progressive Lodge No. 945, F. & A. M., and the Humboldt Commandery, both of Chicago.

## COMPONENT COUNTY SOCIETIES

### PASCO-HERNANDO-CITRUS

The Pasco-Hernando-Citrus County Medical Society held its annual picnic at Panasoffkee Lake, Thursday, July 8. A boat trip and fishing were among the enjoyable events of the evening. A fish dinner was served in a cottage reserved for the occasion. Dr. and Mrs. W. H. Walters, Jr., served as host and hostess, and a hearty vote of thanks was extended to them for arranging and carrying out plans for this enjoyable outing.

### PINELLAS

On July 2 the members of the Pinellas County Medical Society met at the Morton F. Plant Hospital Nurses' Home at Clearwater. The following scientific program was presented: "Case Report," Dr. M. A. Nickle; "X-ray Plate Study," Dr. John Shahan; "Spinal Anesthesia," Dr. M. E. Black, and "Venom Extraction," Dr. W. D. Anderson.

The Society held a round table assembly at the home of Dr. R. K. O'Brien on the evening of July 16. A discussion was held on the proposed program of the State Board of Health for providing certain medical care for families of men in military service.

The Society did not hold a meeting during the month of August.

## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

### THE WELTMANN REACTION IN RESPIRATORY DISEASES IN CHILDREN, DEES, SUSAN C., DURHAM, N. C., AND MORTON, HENRY, SARASOTA, FLA., J. PEDIAT. 21: 514-523 (Oct.) 1942.

The Weltmann serum coagulation reaction was determined in 500 pediatric patients in whom a definite clinical or pathologic diagnosis was made. In acute infections of any type the coagulation bands ranged from 0 to 4, in less severe infections from 4 to 6, and in chronic infections from 6 to 10.

Respiratory infections only were considered in this study. The authors pointed out that in lobar pneumonia the coagulation band is zero at the onset, and remains low until recovery is well established. Bronchial pneumonia has no characteristic band and the values range from 0 to 4. In bronchial asthma the coagulation band is 6 (which is normal value) unless there is some coexisting infection which shortens the band.

As a laboratory test the Weltmann serum coagulation reaction has certain very desirable features. It has a constant value in normal, healthy persons, and definite deviations in cases of acute infections. It is unaffected by many physiologic and nonpathologic factors, such as dehydration, acidosis, and alkalosis, which influence temperature and the white count. Factors which may modify the sedimentation rate such as anemia or allergy do not affect the Weltmann reaction. The value of the test will increase as it is used more widely and as coagulation bands are determined for a wide variety of diseases.

### DOUBLE PULLEY HUMERAL ADAPTATION OF RUSSELL TRACTION, SMITH, DONALD W., MIAMI, SURGERY, 13: 62-66 (JAN.) 1943.

A new double pulley method of humeral extension for the treatment of fracture of the distal half of the shaft of the humerus is illustrated and described as follows:

The patient is placed in bed with the emergency Thomas splint in place and the traction is applied without altering the position of fragments as revealed by roentgenogram upon admission.

A Balkan frame is placed on the bed and a single pulley is attached to an overhead extension arm which is adjusted to allow the desired degree of abduction and flexion. The usual type of hand cage or spreader is applied by adhesive strips to the dorsal and volar sur-



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faces of the forearm. A spreader with one double or two single pulleys attached is fastened to the antecubital region by a felt sling or by moleskin or adhesive tape. In the later case the tender medial aspect of the arm is avoided. The adhesive strip is attached posteriorly and is passed outward over the spreader where it is divided and faced, each half passing about the forearm without adhering until, as it encircles the arm, it reaches the tape posteriorly.

The rope attached to the hand spreader is passed through the pulley on the overhead extension arm of the Balkan frame in order to support the forearm. From there it is passed through one-half of the double pulley system at the elbow, then through a single pulley attached to the end of the Thomas splint and, finally, through the other pulley at the elbow down to the weight below. In this way lateral traction and countertraction are produced to maintain humeral extension.

According to the author, the new method (1) is more comfortable for the patient, (2) prevents posterior angulation of the fracture when the patient is raised for the unusual nursing care, (3) permits more freedom of motion and (4) exerts less force upon the arm for a corresponding amount of axis traction than do other multiple pulley systems.

### ADVERTISERS' NOTES

#### WAR WORKERS BENEFIT BY USE OF SPENCER SUPPORTS

Test cases, recorded by the management of various war industries disclose that scientific abdominal and back support, coordinated to improve occupational posture, has a favorable influence on workers' attendance, morale, general health and endurance.

Spencer Supports were individually designed for a number of workers who had absentee records. Precision records of work hours and production were kept by the management for eight weeks before the Spencer Supports were worn, and for eight weeks after. The result showed a definite increase in work hours and in output. Absenteeism was reduced.

In the reports received from the war workers who wore Spencer Supports, it was noted that the most common benefit derived from support was posture-improvement with consequent relief from backache. It was found that abdominal support, lessening of strain and fatigue, relieved backache and lessened fatigue.

#### A NEW MILITARY GOGGLE

Scoring direct hits on enemy targets has been simplified for gunners by a new military goggle which aids their eyes to see in broad daylight the path of tracer bullets, the American Optical Company announced recently.

In addition to helping gunners estimate accurately how close tracer bullets come to hitting targets, the new goggle also adapts pilots' eyes to darkness. Fliers wearing the goggles can work under full illumination, thus eliminating the 30-minute period previously spent in a dark room to condition their eyes for night flights.

Developed by American Optical scientists, the goggle is fitted with red plastic lenses which act as a light filter by excluding all light except that at the red end of the spectrum. Dark adaptation is therefore possible because the night-vision rod cells of the eye's retina are insensitive to red light.

For other military purposes the same type of goggle is made with clear plastic lenses to protect eyes against wind and dust, with green plastic lenses to protect eyes against the sun's glare, and with yellow plastic lenses to brighten up targets on cloudy or hazy days.

Made of leather and plastics, the goggle is unbreakable, weighs only an ounce, and can be doubled up into a small space. The leather frame contains perforations for ventilation, and its side shields are fitted with a strip of plastic which allows side vision.

Certain divisions of the Army, Navy and Marine Corps are being equipped with the new all-purpose goggle which can be manufactured speedily despite its versatility.



#### CHANGE IN CASEC MEASUREMENTS

Casec now measures six *packed* level tablespoonfuls instead of 12 level tablespoonfuls, as formerly, so that directions to the patient should be amended accordingly. Casec is indicated in colic and loose stools in breast-fed infants, and in fermentative diarrhea, malnutrition, celiac disease and for premature infants. Mead Johnson & Company, Evansville, Indiana, U. S. A.



#### AMERICAN HOME PRODUCTS CORP.

W. O. Frohring, newly-elected director of American Home Products Corporation, manufacturer of drugs, foods and household products, has been appointed special technical consultant to the corporation and its subsidiaries, it was recently announced by Alvin G. Brush, chairman of American Home Products.

In his new post, Mr. Frohring will concentrate on research and development work in connection with new products to be introduced when the war ends, and he will cooperate with the 15 laboratories in the American Home Products organization to achieve this objective.

To free himself for his new duties, Mr. Frohring has resigned as chairman of S.M.A. Corporation of Mason, Michigan, American Home Products' subsidiary and pioneer in the production of milk products for babies including special milk products for premature or ailing babies and for those with milk allergies. Mr. Frohring has played the principal role in S.M.A. Corporation's development and growth since it was founded more than 20 years ago.

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## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

NEW AND NONOFFICIAL REMEDIES, 1943, Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1943.

The current volume of New and Nonofficial Remedies continues, with minor improvements, the convenient and informative system of classification adopted for the 1942 volume. The terminology of the official drugs has been revised to conform to the U.S.P. XII and the N.F. VII. One notes that the valuable bibliographic index now appears on white instead of "India Tint" paper, a wartime necessity no doubt. This index appears before the general index which is now more properly placed at the end of the book. To one accustomed to the old format of New and Nonofficial Remedies the new arrangement appears somewhat awkward but with a little use the wisdom and convenience of the changes become more and more apparent.

Textual changes and revisions do not appear to be as numerous as in some previous editions. The chapter, Digitalis and Digitalis-like Principles and Preparations, has been extensively and somewhat radically revised to keep pace with the changing attitude toward this drug. It is understood that in this revision the Council had the aid of the foremost digitalis authorities, pharmacologists and clinicians alike. Other revisions have been made obviously to keep the book up to date with medical knowledge. To cite a specific revision indicating the increasing skepticism of the Council concerning a drug, it is interesting to contrast the following sentence in the 1942 general article on Chaulmoogra Derivatives, "The therapeutic properties of chaulmoogra oil appear to be due to these optically active unsaturated fatty acids of the chaulmoogric series," which in the 1943 edition reads "Any therapeutic properties chaulmoogra oil may possess would appear to be due to these optically active unsaturated fatty acids of the chaulmoogric series."

No such spectacular new additions as the appearance in a previous volume of the sulfonamides is to be noted. Among the more noteworthy of the new additions are Nikethamide, the central nervous system stimulant which was first introduced as Coramine; Diethylstilbestrol, the synthetic estrogen; Trichinella Extract for the diagnosis of trichinosis; and Zephiran Chloride, a mixture of alkyl dimethyl benzyl ammonium chlorides, an interesting new anti-infective agent.

No one can examine the successive volumes of New and Nonofficial Remedies without increasing his profound respect for the faithful and unselfish work of the Council on Pharmacy and Chemistry in the cause of rational therapeutics. Each volume represents a progressive milestone on the road of medical science.

Cloth. Price, postpaid, \$1.50. Pp. 772. Chicago: American Medical Association, 1943.



ALLERGY. By Erich Urbach, M. D., Associate in Dermatology, University of Pennsylvania School of Medicine, Philadelphia. Conceived on the broadest foundation of knowledge and experience, by a writer of international eminence, Dr. Urbach's book constitutes a basic introduction to this vital field. General practitioner and specialist will find it a concrete guide for the diagnosis and management of the diseases of hypersensitivity. Particular stress is laid on the clinical and technical advances of today. At the same time, the discussion embodies a widely inclusive critical survey of the accumulated scientific research on which the principles of allergy are based. Fabrikoid. Price, \$12.00. Pp. 1,100, with 400 illustrations. New York: Grune & Stratton, Inc., 1943.

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GYNECOLOGY—Two Weeks Intensive Course starting October 18. Clinical and Diagnostic Courses.

OBSTETRICS—Two Weeks Intensive Course starting October 4.

OPHTHALMOLOGY—Two Weeks Intensive Course starting September 27. Course in Refraction Methods October 11.

OTOLARYNGOLOGY — Two Weeks Intensive Course starting September 13.

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## CHARGES AND SUGGESTIONS

*Dear Friends:*

This issue of the State Journal brings you a copy of this year's charges. These charges, approved by our State Advisory Board, are to be used by you as an inspiration and guide for your program of the coming year. Please follow them as closely as is possible for your particular group and location.

Our summer days are gone, and the time of cooler weather and increased energy is before us. Let's set our hearts and minds to the tasks that challenge us.

For most of us our work along defense lines is well under way. We know what to do and how to do it. The tendency to become complacent is, however, always in our nature. Work faithfully on your local defense projects. Your national and state defense chairmen will send you messages from time to time. Give these messages your careful consideration. Our emphasis this year, as last year, is on defense. You will note that the Advisory Board is stressing the making of Red Cross bandages. Remind your group of this charge at each meeting.

Our Publicity chairman, Mrs. Copeland, asks that you send items of your activities for publication in the Journal. We cannot appreciate too much the untiring work she does for our State's press and publicity. Please cooperate with her. Make it a point to send in at least one write-up of your work for publication. By all means appoint an active publicity chairman, and send her

name and address to Mrs. Copeland as soon as possible.

May you also be reminded to read the Woman's page in the State Journal. It is your only contact with the various groups in the state. Bring a copy to your meeting and pass it among the members.

We all need, now more than ever, the help, comfort and strength that comes from companionship with those of mutual understanding of the needs of our times. As we serve humanity well, we serve ourselves to better living and real happiness.

## STATE CHARGES 1943

1. Make a genuine effort to put over the Bulletin this year.
2. Continue diligently to subscribe to and distribute the magazine Hygeia.
3. Cooperate 100% with the Legislative Committee.
4. If possible, hold an Annual Health Institute Day, or something of similar importance.
5. Cooperate with your local Cancer Field Army and Tuberculosis Association.
6. Appoint a Defense chairman, and follow the program outlined by the National.
7. Cooperate actively with the Red Cross, particularly in the making of Red Cross dressings.
8. Do not forget Archives. Send all biographies to the Florida Medical Association, Box 1018, Jacksonville 1, Florida.

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STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association .....	Eugene G. Peek, Ocala .....	Shaler Richardson, Jacksonville ..	To Be Announced
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna ..	Stewart Thompson, Jacksonville ..	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville ..	“ “ “ ..	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland .....	“ “ “ ..	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach ..	“ “ “ ..	Miami, Postponed
Alabama Medical Association .....	H. B. Searcy, Tuscaloosa .....	D. L. Cannon, Montgomery .....	
Georgia, Medical Assn. of .....	W. A. Selman, Atlanta .....	E. D. Shanks, Atlanta .....	
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg ..	Kenneth Phillips, Miami .....	To Be Announced
Dental Society, State.....	A. Malcolm Smith, D.D.S., Tampa ..	H. L. Cartee, D.D.S., Miami .....	To Be Announced
Derm. and Syph., Soc. of .....	Wiley M. Sams, Miami .....	Lauren M. Sompayrac, Jacksonville ..	Miami, October, 1943
East Coast Medical Association .....	T. C. Kenaston, Cocoa .....	I. M. Hay, Melbourne .....	Postponed
Hospital Association .....	Mr. W. E. Arnold, Jacksonville ..	Miss Katharine Moyer, Lake Wales ..	
Industrial Surgeons, Assn. of .....	Frank D. Gray, Orlando .....	Richard H. Walker, Orlando .....	
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville ..	Chairman .....	
Nurses Association, State .....	Mrs. Ann Thompkins, Leesburg ..	Miss Madalee Hazel, St. Petersburg ..	
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville ..	C. E. Dunaway, Miami .....	To Be Announced
Pathological Society.....	L. Y. Dyrenforth, Jacksonville ..	Iva C. Youmans, Miami .....	To Be Announced
Pediatric Society .....	Ludo von Meysenbug, Daytona B. ..	Robert Blessing, Ft. Lauderdale ..	To Be Announced
Pharmaceutical Association, State .....	Mr. H. B. Douglas, Bonifay ..	Mr. R. Q. Richards, Ft. Myers ..	Miami, To Be Announced
Public Health Association .....	Leland H. Dame, Sanford .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	John N. Moore, Ocala .....	Walter A. Weed, Orlando .....	To Be Announced
Railway Surgeons' Association .....	Frank D. Gray, Orlando .....	W. C. Page, Cocoa .....	To Be Announced
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales ..	Mrs. May Pynchon, Jacksonville ..	
Chattahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine ..	Robert B. McIver, Jacksonville ..	Postponed
Gulf Coast Clinical Society .....	G. G. Oswalt, Mobile, Ala .....	C. L. Rutherford, Mobile, Ala ..	Postponed
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola .....	Kenneth Phillips, Miami .....	
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta .....	Postponed
Southern Medical Association.....	Harvey F. Garrison, Jackson, Miss. ..	Mr. C. P. Loranz, Birmingham ..	Cincinnati, Nov. 16-18, 1943
Swanee River Medical Society.....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City .....	



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				Total	Paid	
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Duval *Clay	T. Z. Cason, M.D. 2033 Riverside Ave. Jacksonville	F. A. Copp, M.D. 411 St. James Bldg. Jacksonville	1st Tuesday 8:15 P.M.	195	193	
Marion *Levy	T. Hartley Davis, M.D. 202 Commercial Bk. Bldg. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	29	27	
Nassau	Geo. A. Dame, M.D. Fernandina	E. F. Waite, M.D. Fernandina	2nd Wednesday 8:00 P.M.	9	100%	
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# The JOURNAL *of the* Florida Medical Association, Inc.

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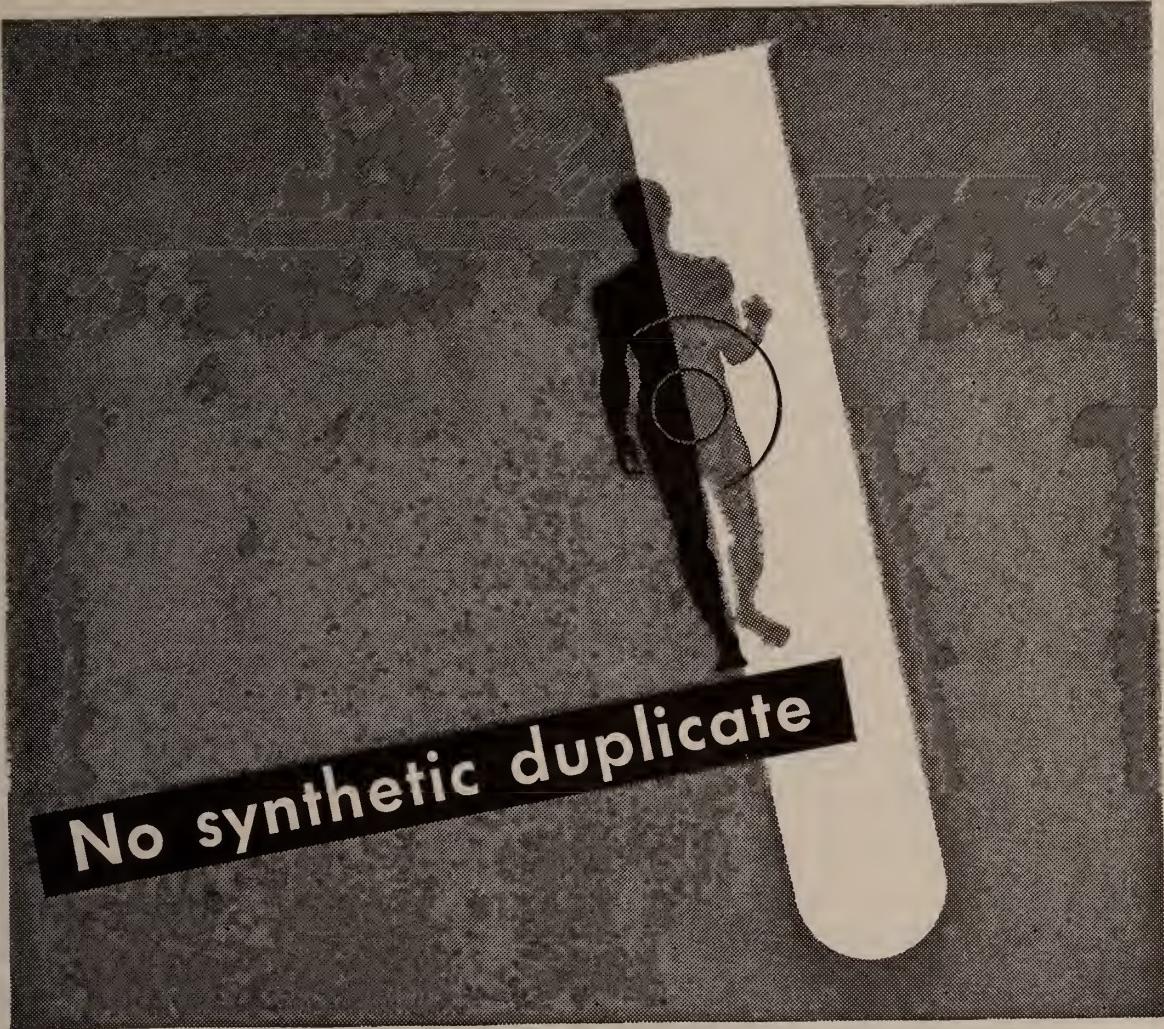
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

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Jacksonville, Florida, October, 1943

No. 4

## THE DOCTOR IN THE WAR EFFORT

S. W. FRENCH

COLONEL, MEDICAL CORPS (USA)

ATLANTA

To cover the subject chosen for this paper in chronologic order, it is necessary to start with the civilian doctor in time of peace, after the declaration of war and when he is commissioned into the Medical Corps of the Army. Then one must follow his career during the period of his indoctrination and through the stage of his greatest value to the service, and finally return him after the war to his civilian status.

At the present time, it takes longer to obtain a degree in medicine and requires greater expense than for any other profession. The student must have certain premedical credits in order to attend any first class medical school. He must have a bachelor's degree as a prerequisite of admission to some schools; the degree is preferable in all cases. The four arduous years of his medical course are followed by at least one year of internship. Now the student is ready to start the practice of medicine as an individual. Depending upon certain conditions, the new doctor will work for an indefinite period in getting himself established. All of this training takes a considerable sum of money, and many young doctors are deeply in debt for their medical education for years after they start practicing. War clouds loom, and eventually the world is again at war. There can be no question but that doctors are as patriotic as any other group. They are, however, in a quandary as to their most pressing obligations. The country is calling them to join the armed forces. Their creditors are calling on them to meet their financial obligations long overdue.

The solution of the problem is not so difficult with youngsters who are just finishing their medical education and have not further obligated themselves for the necessary equipment with which to carry on a private practice. Nor is it so difficult with those who have been in practice long enough to get completely out of debt. These two classes of doctors are, therefore, usually the first to answer the call of military service. It often takes some little time for those in the first

group to arrange their personal affairs so that they feel they can make the change with fairness to themselves and to their associates.

Now consider the civilian doctor from all groups who has finally been commissioned in the armed forces as a medical officer. He receives his orders from the War Department to report on or about a certain date at a designated station. He may be ordered to duty with a fixed hospital, either station or general; he may be ordered to a camp for duty with a technical or tactical unit. In fact, when he receives his orders, he knows little about what his duties will be. When he reports, he finds conditions entirely different from conditions in civil life. He must even change his mode of dress and get into a uniform. He knows nothing about military life unless he has had ROTC training or service in the National Guard. It takes time for his readjustment. Some snap into the change quickly while others take a longer time, and some few never really made the grade.

Many doctors who have a nervous temperament are never quite able to readjust themselves to the new life. Some of them get along passably well until they receive orders for overseas duty. Then the break comes in the form of a complete nervous collapse, sudden deafness, a severe flare-up of a long forgotten sinus condition, or one or more of many other hysterical combinations. These few must necessarily be partially or wholly separated from the service as a liability rather than an asset.

To turn back to the period of indoctrination of the newly commissioned doctor, when he has obtained his uniforms and equipment and at least begins to look like a soldier, he begins to realize that he is no longer an independent free lance. He finds that he is merely a cog in a large wheel and that when the wheel begins to grind, the cog must follow along or get lost in the shuffle. He is assigned to some form of medical duties, and his basic training is started in addition to his routine medical work. The basic training covers subjects intended to acquaint him with the more common military customs in order to commence his transformation from a doctor into a medical officer.

It might be well at this point to give a definition of a medical officer. He is a doctor who,

through training and experience, has acquired knowledge of military customs, laws, regulations and procedures. In other words, he is a medical soldier and not just a doctor. Depending upon the amount of his military knowledge, he is capable of efficiently handling medical troops from the smallest medical unit to the largest. In this process of transformation of a doctor into a medical officer, he not only does a certain amount of medical work, but he also attends drills, classes and demonstrations at almost any time, place or situation. Changes in his daily routine are decidedly sudden. He gets up in the morning at a certain time and eats at certain times; his whole day becomes routine from start to finish. He is not required to go to bed at any certain time, but he will probably be willing to retire much earlier after his strenuous day than he ever dreamed of at home. Gradually this routine becomes automatic, and from then on his usefulness to the service increases with the rapidity with which he is able to absorb such subjects as Army Regulations, Customs of the Service, School of the Soldier, Manual of Courts Martial, Field Service Regulations, the responsibility and accountability of government property, military medicine with special emphasis on tropical medicine, military surgery with special reference to war wounds, camp hygiene and sanitation, and the many other subjects with which he must become more or less familiar before he reaches the ultimate transition from doctor to medical officer. It is a source of the greatest satisfaction to see how the majority of these youngsters study and work on these many subjects which are entirely foreign to them. Of course, some few gripe and wonder why they should fill their heads with things they do not need to know in order to treat civilian sick.

It is surprising to note the change in his attitude when the doctor at length realizes that he has a real place in the armed forces as a medical officer. He may become interested in some branch of medicine or surgery about which he previously knew little. He may take a keen interest in the development of some gadget which can be used to short-cut certain procedures. It dawns upon him that he is no longer simply a doctor, but that he is a medical officer and is now qualified to take his place wherever and whenever he is most needed. He ceases to look upon new arrivals as varmints; instead he takes delight in assisting them and having an opportunity to demonstrate his military knowledge. He no longer dreads the

day when he will be ordered overseas. He has confidence in himself now and knows that he can handle his job and handle it well.

The officers of the regular medical corps have always realized that they were only a nucleus from which a vast force must spring in time of war. They have chosen to make their career in one of the armed forces before they are 32 years of age, which is the age limit for admission. There are usually reasons for making this choice. Some have a desire for the opportunity to see the many parts of the world which service in the Army or Navy will offer them. Some cannot make up their minds that they would be satisfied with any one restricted locality for the duration of the period of their active practice. They know they will have opportunities to see parts of the world which they would probably never see if they settled down in private practice. They realize that they will be able to make a great many friends during their years of service and changes of stations.

Probably one of the most attractive thoughts is with reference to their status in later years. They realize that they will be retired at the age of 64 years with pay which amounts to about 4 per cent interest on an investment of \$100,000. They also know that few private practitioners can take it easy at that age with an equal feeling of financial security. True it is that they can never become wealthy through the salary they receive while on active duty. There are certain conditions, however, that more than make up for the decrease in money. First and foremost is the feeling that they are working to relieve suffering among the sick and injured the same as are their civilian brothers. In addition, there is the feeling that they are an integral part of a machine which is building itself up to assist in the preservation of peace and freedom for our glorious country.

The regular officer knows that in time of war, his job will be a difficult one. When the first World War began, the regular corps was well under 500 in strength. The Medical Corps of the National Army increased to over 30,000 before the armistice. In the present war, there were 1,200 regular medical officers on Dec. 7, 1941. It has been estimated that before the present upheaval is finished, between 45,000 and 60,000 doctors will be required in the Army alone. It is apparent, therefore, that the country is absolutely dependent on the civilian doctors for such a tremendous increase. One of the first and most

important tasks the regular officer has is the organizing, equipping and training of this vast number of recruits into the Medical Corps. In addition to the doctors, there are the members of the Dental, Veterinary, Sanitary, and Medical Administrative Corps, and the Nurse Corps to be similarly trained. The manner in which the Medical Department will function during this war depends upon the manner in which the reserves are trained by the regulars. After they have been trained and assigned to tactical or technical units, they are more or less on their own and must carry on to the best of their training, knowledge and judgment if the nation is to come out victorious in this terrible struggle.

The period of demobilization for the medical officer is almost as trying as was the period of indoctrination into the service. In the first place, he usually feels that now the war is over, he should be discharged immediately and allowed to return to his home to take up his civilian practice again. The fear is ever present that perhaps all the other doctors will get home before he does and quite possibly get some of his old patients away from him. This reasoning is quite rational. On the other hand, it must be borne in mind that it is impossible to disband millions of men overnight and that as long as they are still in service there must be doctors to take care of them.

Experiences after the first World War showed that many medical officers went to any extreme to secure an early discharge. Political friends were set busy with a view to using their influence with the War Department for their early release. Many proved cases of false claims of sickness in their immediate family were used in an effort to obtain release from further military service. This situation has been partly clarified for the present struggle by Public Law 338, 77th Congress, 1941. This law specifies that all officers and enlisted men will serve for the duration of the war and for the six months immediately following the termination of the war. This law probably does not mean that all of the officers and enlisted men will actually serve for the six months immediately following the war. They will be discharged as soon as conditions permit and sent to their homes. The proviso of the law merely permits the retention of officers and enlisted men for six months if they are actually needed.

Before closing this part of my paper, I should like to mention a few of the common "gripes"

with which the newly appointed medical officer is often confronted. Newly appointed officers who are assigned to field units, and especially those assigned to tactical troops, often see no really sick patients for some time. They will hold sick call for their own organization, but if a man is sick enough to require hospital treatment, he will be sent to the Station or Camp Hospital and will not be seen again until he is ready for duty. The medical officers with both the tactical and technical units (field units) will be kept extremely busy with basic training for the first six weeks or so. Then they will swing into group training so that they will be ready as soon as possible for their ultimate duty, which will be in the field in almost any part of the globe.

The tactical medical officers who are assigned to battalions, regiments or higher echelons of the fighting troops must learn to coordinate their work with other medical echelons so that first aid treatment and evacuation of patients will be accomplished with the least delay compatible with the patient's welfare. They must then be ready to advance with their organizations in order to carry on with their specific duties as their troops advance.

The technical medical officers who are assigned to such units as numbered Station and General Hospitals, Evacuation Hospitals and Surgical Hospitals, are not only instructed in the field training, but must also acquaint themselves thoroughly with the specific professional duty or duties they will perform as a member of a mobile professional medical unit. The time consumed with this training will vary in direct proportion to the efficiency of the instructors and students. Ordinarily an intelligent staff can become proficient under the tutelage of intelligent instructors within a period of six months. During all this time, the medical officers will see no sick persons except among their own staff while holding sick call. After the training period has been completed, it is customary to attach the officers, nurses and enlisted men to the permanent Camp or Station Hospital where they are under training, for temporary duty. During this time and until alerted, they will understudy the particular position which has been assigned to them in their own hospital. The chief of medical service will, for example, understudy the chief of medical service in the permanent hospital.

Another question which bothers most doctors is the one of the rank which they will receive

when they first join the service. As a matter of fact, this is one of the hardest nuts to crack with which the Office of the Surgeon General has to deal. Age, previous service and professional qualifications are all taken into consideration in the evaluation of each candidate. To assist in the evaluation process, WD, AGO Form No. 178-2 is made out by each applicant and sent in to the War Department together with the Classification Questionnaire for Reserve Officers (Form No. 178). Form No. 178-2 is used by doctors, dentists and veterinarians. In addition to all of the information which the candidate furnishes, use is made of information collected by the American Medical Association, medical directories and specialists' directories. It is amusing in some cases to read the special qualifications checked by the doctors themselves. If in half of the subjects checked by some they were really proficient, each of these candidates would deserve no rank lower than that of a field marshal. Even with the assistance of all this information, it is difficult to get every doctor placed in his appropriate place, especially in the place to which he thinks he is entitled.

This much can be said of the present system—it is so much better and is producing so much less discontent, infinitely less in fact, than the system used in the first World War that there is no use wasting time in comparing the two systems. It can further be stated that no system no matter how carefully it is administered, will prove entirely satisfactory to all concerned 100 per cent of the time.

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## PRELIMINARY STUDY IN THE USE OF CONTINUOUS CAUDAL ANESTHESIA

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In September of 1942 Edwards and Hingson<sup>1</sup> of the United States Public Health Service, U. S. Marine Hospital, Staten Island, New York, published a report on "Continuous Caudal Anesthesia in Obstetrics." In October of that year Hingson and Southworth<sup>2</sup> of the same hospital published a further report on continuous caudal anesthesia on surgical patients.

I have been interested since last June when I was much impressed by the clinical lectures and moving pictures given by a representative of the Lahey Clinic at the convention of the American Medical Association on spinal anesthesia, following the work of Lemmon.<sup>3</sup> So far I have not been able to sell Drs. Colquitt Pearson and R. S. Sappenfield on the idea of employing it. With the use of nembutal and hyoscine to produce preliminary hypnosis, I am, however, gradually doing more gynecologic surgery and surgery of the upper portion of the abdomen under spinal anesthesia.

In January of this year, after discussing sacral anesthesia at length with Dr. C. G. Mentzer and Dr. Colquitt Pearson, I tried the use of continuous caudal anesthesia in several obstetric cases. There is nothing original in this work. The technic I use, developed by Hingson and Edwards,<sup>4</sup> is as follows:

1. After the accoucheur has made a thorough survey of the case and is convinced that the true labor pains of the first stage of labor have begun, the patient is prepared for continuous caudal anesthesia. If she is a primipara and a labor of several hours is anticipated, the anesthesia may be started while she is in her hospital bed. Such a course may also be selected for the multipara in whom the accoucheur encounters dystocia or protracted labor.

Parturients who by their course and the physical findings give indication of early delivery are transferred immediately to the delivery room. I give no sedation such as barbiturates unless there is extreme nervous tension with anxiety on the part of the patient.

2. The administration of the anesthetic is performed with the patient in the knee-elbow or knee-chest position for the insertion of the needle

in the sacral canal. It can also be administered with the patient on her side in the position of universal flexion as for spinal anesthesia.

3. The tip of the coccyx is palpated with the middle finger, and the thumb is used to find the inverted V-shaped notch of the sacral hiatus, which is usually from half an inch to two inches cephalad from the inferior caudal tip. The middle finger is then held in this notch as a guide, and a skin wheal is raised below this point with the local anesthetic solution.

4. A sixteen gauge Lemmon malleable silver spinal needle is then inserted through the skin wheal and through the sacral hiatus into the sacral canal until the needle comes to rest on the anterior bony wall of the canal. The needle should be inserted within the canal for a distance of from 5 to 7 cm. approximately.

5. The hub of the needle is then securely attached to the rigid rubber tubing of the Lemmon continuous spinal apparatus by means of a Luer lock connector.

6. An initial dose of 30 cc. of a 1½ per cent solution of metycaine in physiologic saline is injected into the sacral canal at an even speed in one minute. For this procedure I use a continuous flow 5 cc. syringe with a rubber tube inlet from a covered sterile graduated flask containing the anesthetic solution. In my experience the parturient is free from pain within five minutes.

7. The hub of the caudal needle may be secured in the median raphe just caudal to the sacral hiatus by means of a small strip of adhesive tape which does not interfere with the antiseptic preparation of the patient.

8. With the anesthetist carefully transposing the connected tubes and the syringe to a small Mayo stand beside the delivery table, the patient is simultaneously permitted to turn on her back.

9. The parturient is now placed in the lithotomy position for the delivery of the baby. The perineum can be scrubbed with soap and water. The vulva and even the vaginal vault may be painted or sprayed with one of the antiseptic tinctures such as mer cresin or merthiolate without discomfort to the patient.

10. The anesthesia can be continued indefinitely by serial injections of the anesthetic solution at intervals in amounts varying with the individual case. Most of my patients have been comfortable if 20 cc. of additional anesthetic solution is injected every thirty to forty minutes. The interval of the serial injections may be shortened,

and the amount may be increased if the patient should have any discomfort.

I have used this type of anesthesia only on primiparas and have had uniformly good results. With the patient placed in the knee-chest position, I secure the needle in place with adhesive tape, and thereafter she may lie in any position that is most comfortable until the time of actual delivery. The following records are typical:

#### REPORT OF CASES

Case 1.—A primipara was admitted to the hospital at 8 p. m. The fetal heart tones were 134; the systolic blood pressure was 190. Contractions were moderately severe and occurred every three to five minutes. The onset of labor had occurred at 5 p. m. Three grains of nembutal and 1 cc. of synkamin were given on admission. On rectal examination at 9:35 p. m., the presenting part was high with 2½ fingerbreadths' dilatation. Thirty cubic centimeters of a 1½ per cent solution of metycaine was introduced into the sacral canal. The blood pressure at 9:40 p. m. was 134 systolic and 90 diastolic; at 9:45 p. m. it was 120 systolic and 72 diastolic; at 10:20 p. m. 20 cc. of metycaine was injected. At this time the blood pressure was 130 systolic and 90 diastolic; at 10:30 p. m. it was 128 systolic and 90 diastolic. The patient was sleeping between contractions. On rectal examination at 10:15 p. m. the rim of the surface presenting part was high. At 10:50 p. m. the membranes were presenting on the perineum, and the patient was taken to the delivery room. An injection of 20 cc. of metycaine was given at 11 p. m., at which time the blood pressure was 124 systolic and 96 diastolic. At 11:05 p. m. the blood pressure was 130 systolic and 90 diastolic. At that time the membranes ruptured. At 11:15 p. m. the blood pressure was 130 systolic and 84 diastolic. Another injection of 15 cc. of metycaine solution was given. Low forceps delivery of a living infant girl at 11:30 p. m. followed episiotomy on the right side. The baby cried spontaneously. This primipara was in labor for six and a half hours. She was given continuous caudal anesthesia for three hours, and a total of 85 cc. of a 1½ per cent solution of metycaine was used.

Case 2.—A primipara was admitted to the hospital at 5 a. m. Contractions were irregular and at 7 a. m. the patient was sleeping. Three grains of nembutal and 1 cc. of synkamin were given on admission. At 3:30 p. m. the presenting part was high and rectal examination showed dilatation of 1 fingerbreadth. At that time 30 cc. of a 1½ per cent solution of metycaine was given. Previous rupture of membranes, slow labor and irregular contractions occurred in this case. Contractions were not controlled by the anesthetic solution from 7:30 p. m. to 9:30 p. m. Recheck of the needle at this time revealed that it had become displaced from the caudal canal. It was reinserted at 9:30 p. m., and the initial dose of 30 cc. of metycaine was repeated. The discomfort was now controlled. Low forceps delivery of an infant girl took place at midnight. The baby cried spontaneously. The total amount of metycaine solution administered was 280 cc., of which I estimated 65 cc. was given subcutaneously during the time the needle was displaced from the caudal canal.

I have used this method of anesthesia without preliminary administration of nembutal and find patients are a bit restless, especially if the family is with them during labor. In a clinic type of patient who has no visitors, the metycaine alone would in my opinion be sufficient to relieve physical pain. I prefer, however, to give nembutal early in the first stage of labor and then use mety-

caine when the cervix is dilated from 1 to 3 finger-breadths. The cervix rapidly dilates, and the presenting part appears on the perineum. I have not used this type of anesthetic in multiparas nor in cases of abnormal presentation.

Edwards and Hingson<sup>1</sup> recommended this anesthetic highly in cases of eclampsia and cited a case in which the blood pressure dropped from 220 systolic and 110 diastolic to 140 systolic and 90 diastolic following its use. The blood pressure was checked every fifteen minutes in this case, and the systolic pressure at no time exceeded 150. This patient was delivered spontaneously of a five pound healthy infant thirteen hours after she had been given the anesthetic.

#### CONCLUSION

I believe this type of anesthetic is time-saving as well as safer for the patient. In no instance have I noted a change in blood pressure later than fifteen minutes after the initial dose of metycaine was administered. Patients are quiet and cooperative and as the effect of the anesthetic wears off, they will themselves request that more be given. It is necessary to have a competent nurse to check rectal examinations, as once dilatation has begun, more rapid dilatation of the cervix occurs. No discomfort is suffered by the patient during episiotomy, forceps delivery, or repair of episiotomy. The patient is placed back in her bed and given the regular diet at the next mealtime. There is no abnormal loss of blood, and the placenta is removed intact by Credé's method. I see no objection to having these patients in the knee-chest position in order to introduce the needle into the sacral canal and I believe one obtains more even distribution of the anesthetic solution than he would, were the patient in the lateral position.

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#### AQUEOUS VANADIUM TETRACHLORIDE AND ITS POSSIBLE USE IN SYPHILIOLOGY

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This report concerns a new reaction in syphilology. The investigation was carried out in the hope that a new spinal fluid test for syphilis might result. We are not able to say that a new test reaction has been found, but we do state that the reaction described should be of value in tracing the effect of treatment.

In their research on quinine and its effect on the auditory nerve of the fetus, Taylor, Dyrenforth and Pollard<sup>1, 2, 3</sup> noted that syphilitic and normal spinal fluids behave differently. This observation led one of us (Pollard) to suggest that a chemical reaction might be discovered which would be capable of demonstrating syphilis in the spinal fluid. This investigation has carried the suggestion as far as is practical in a chemical laboratory.

It is known that spirochetes have the property of generating lipoids in the system of an affected person. The source of these lipoids is not known; they may come from the host or the parasite. Kahn<sup>4</sup> and other modern authorities were of the opinion that these lipoids cause the body to produce specific globulin which removes the lipoid in some manner. This author also believed that the globulin, directly related to the spirochetes through the lipoids, is the material upon which the Kahn, Wassermann and other serologic test reactions depend. It is clear that this specific globulin must replace a part of the normal globulin since a positive serologic reaction may occur whether there is excess globulin in the spinal fluid or not. Moore<sup>5</sup> emphasized this point. He stated that tests for excess globulin in the spinal fluid are meaningless as soon as treatment has been started, since in many cases it disappears immediately. Even though the treatment is not of sufficient strength to be of use in neurosyphilis, this excess globulin often disappears. This product must then be a nonspecific globulin and

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different from the globulin giving serologic reactions, since in all such cases the serologic reaction remains positive. We may conclude that there is a specific globulin which replaces part of the normal globulin and upon which the serologic reactions for demonstrating syphilis depend.

Boyland<sup>6</sup> made an investigation of the colloids of normal serum and their reaction with vanadic acid. He tried to explain the precipitation of such colloids on the basis of electrostatic charges and their neutralization by the oppositely charged acid particles. As long as no mixture of colloids is present, this explanation is satisfactory. Albumin precipitates at pH 4 and euglobulin at pH 5.2. As soon as a mixture of these two colloids is dealt with, precipitation takes place at pH 4.5 or less, depending on the concentrations. The amount of vanadic acid is not that required by theory, but is less. Boyland<sup>6</sup> gave the following conclusion with regard to the mixtures: The solubility of the euglobulins is possibly due to complex formation with the electrolyte necessary for solution; this complex then appears to react specifically with the vanadic acid.

Neri<sup>7</sup> sought to make some use of the reaction postulated by Boyland<sup>6</sup> by applying it to the spinal fluid of psychiatric patients. In the first experiment he attempted to make a quantitative determination of all the proteins in the spinal fluid by mixing the fluid with vanadic acid and then lowering the pH. He supposed that at the proper pH each protein would precipitate. This expected behavior failed to occur in actual practice.<sup>8</sup>

In his second experiment Neri<sup>7</sup> dropped the spinal fluid into exactly 5 ml. of vanadic acid solution. The number of drops required to produce turbidity was supposed to indicate pathogenicity. This experiment did not work exactly as he had expected. From fifty mental patients, 21 of whom were syphilitic, 27 fluids gave turbidity with less than 10 drops, the remaining fluids requiring some 20 drops. Of these 27 positive reactions, 17 were syphilitic samples. This author concluded that vanadic acid had some tendency to produce flocculation with syphilitic spinal fluid. No matter how enthusiastic he may have been, it is easily seen that there was nothing definite to be gained by repeating work which gives so many false reactions.

Quite by accident we have carried the work of Boyland<sup>6</sup> and Neri<sup>7</sup> to a higher level. With no knowledge of their work, we discovered a reaction of vanadic acid of another type. This new re-

action, hereafter referred to as the PLV (Pollard-Leopold Vanadium) reaction, appears to have greater specificity and sensitivity than any proposed reaction of vanadium, or other ion.

#### EXPERIMENTAL WORK

Several reactions were studied in the course of this investigation. Our approach to the problem was a study of the effect of additions of spinal fluid to various metal salt solutions and subsequent crystallization of the mixtures. Potassium dichromate and nitric acid and vanadium tetrachloride were found to have definite reactions with syphilitic fluids. These reactions were studied in detail. Several ions were investigated as alternative possibilities, but were found to be of no value. These were ferric, molybdate, cupric, cuprous, arsenous and trivalent bismuth ions.

The first reaction of value noted was that of 2.5 per cent  $K_2Cr_2O_7$  and 1:100  $HNO_3$  with syphilitic spinal fluid. This reaction is observed if equal-sized drops of the three components are placed side by side on a microscope slide, mixed with a small glass rod and viewed under low power of the microscope. Taccone<sup>9</sup> proposed a similar reaction for macroscopic use. His technic varied in the acid employed. He made use of trichloracetic acid and claimed that differential diagnosis was possible on the type of flocculation formed. We observed no such difference. Both nitric and trichloracetic acids have been proposed for use in the determination of albumin. Their action is similar in such a reaction. We made a total of 100 tests with this reaction, the results of which are shown in table 1. It was found that the solutions had to be made fresh for each set of samples or the sensitivity would vary.

TABLE 1  
SUMMARY OF RESULTS WITH  $K_2Cr_2O_7-HNO_3$   
REACTIONS

Total Wassermann- and Kahn-negative nonsyphilitic spinal fluid samples.....	35 (X)
Total Wassermann- and Kahn-positive syphilitic spinal fluid samples .....	38 (Y)
Total Wassermann- and Kahn-negative treated syphilitic spinal fluid samples	27 (Z)
Total number of samples .....	100
$K_2Cr_2O_7-HNO_3$ reaction results with (X).....	32 —, 2 +, 1 ±
Percentage of disagreement with diagnosis .....	absolute=8.6%
$K_2Cr_2O_7-HNO_3$ reaction results with (Y).....	38 +
Percentage of disagreement with diagnosis .....	absolute=0%
$K_2Cr_2O_7-HNO_3$ reaction results with (Z).....	5 —, 15 +, 7 ±
Percentage of disagreement with diagnosis .....	absolute=81.5%

The second reaction studied was that of an aqueous solution of vanadium tetrachloride ( $VCl_4$ ) and syphilitic spinal fluid. In order to determine whether the original stock solution of this material could be reproduced, another sample of solid  $VCl_4$ , C. P., was secured, and a duplicate stock solution was prepared from it. The procedure used in the preparation of this duplicate solution is given in full, since any attempt to follow this work would first necessitate preparation of the reagent.

As purchased, solid  $VCl_4$  has probably oxidized to  $VOCl_3$ , at least partially. In order to be sure there is some  $VCl_4$  present, the solid is treated with chlorine gas and gently heated. In a large test tube, fitted with a two hole stopper, is placed a 2 Gm. of the solid material. Into one hole of the stopper is fitted a tube from a chlorine generator, the tube reaching to within  $\frac{1}{2}$  inch of the bottom of the test tube. Into the second hole of the stopper is fitted a short exit tube. The exit tube is connected to a safety tube, and this is in turn connected to a flask half filled with 50 per cent NaOH solution. The generator contains NaOCl, and chlorine is produced by the action of concentrated HCl. The dropwise addition of the HCl provides an easily regulated source of chlorine.

The system is swept clear of air, and then the solid is heated gently with a small moving flame for ninety minutes. A steady stream of chlorine is maintained throughout the heating. After the heat has been removed, the chlorine is stopped, and the system is allowed to cool to room temperature. The solid is then removed to a 40 Ml. centrifuge tube and about 25 Ml. of distilled water ( $pH = 6.6$ ) is added. The tube is shaken for five minutes and then centrifuged to clear the blue solution. The resulting solution is filtered through a fine quantitative paper. This blue filtrate contains  $VO^{++}$ ,  $Cl^-$  and  $H^+$  ions. These arise by the hydrolysis of  $VCl_4$  in accord with the following equation:



It is likely that the solid  $VCl_4$  prepared contains some  $VOCl_2$ , and for this reason pure liquid  $VCl_4$  was not used in the preparation of the duplicate stock solution. The pH of such a solution would be different, and in colloid precipitations pH is very important.

After the solution has been filtered, it is analyzed colorimetrically and diluted to give a solution containing from 13 to 14 Gm. of  $VCl_4$

per liter. This concentration is about 1:2 saturated solution and is called stock solution hereafter. It is essential that the stock solution be allowed to age a week before use. The importance of this precaution is shown in table 2 which demonstrates the lack of sensitivity when a stronger solution is used to prepare the actual reagent.

TABLE 2  
RESULTS OF  $VCl_4$  REACTIONS WITH SPINAL FLUIDS  
SHOWING EFFECT OF AGING ON 1/2  
SATURATED  $VCl_4$

Spinal fluid sample number	Kahn reaction	$VCl_4$ reaction saturated	1/2 sat'd stock
90	—	—	—
91	—	—	—
92	—	—	—
93	—	—	—
94	—	+	—
95	—	—	—
96	—	—	—
97	—	—	—
106	+	+	+
107	+	+	+
108	+	+	+
109	+	—	++ <sup>1</sup>
110	+	—	—+ <sup>1</sup>
111	+	+	+
112	+	+	+
113	+	+	+
114	+	+	+

<sup>1</sup>Samples 109 and 110 contained bacterial contamination. Their reactions were so weak as to be called doubtful in the final summary of results.

After allowing the stock to age a week from 2 to 3 Ml. of it are diluted to yield a solution containing 1.4410 Gm. of  $VCl_4$  per liter. This dilution is allowed to oxidize until all the vanadium is in the pentavalent state, as shown by a clear yellow color. The oxidation is hastened by the addition of 1 or 2 drops of 3 per cent  $H_2O_2$ . This illustrates another reason for desiring reproducible acidity and low acidity, for, in addition to changing the reaction with colloids, high acidity would stop the oxidation. This result is shown by the following equation:



When this oxidation is complete, the vanadic acid forms polyacids by loss of water, the principle one being  $H_4V_6O_{17}$ . The work of Neri<sup>1</sup> indicates that if this solution of poly vanadic acid could be sensitized, it might be of use in syphilology. We have found that it is easily sensitized by the addition of a solution of the same vanadium content having its vanadium in the tetravalent state. In order to determine exactly the ratio of volumes of the oxidized and unoxidized solutions which should be mixed for use as reagent, trial and error methods are used. A fresh

dilution of the stock solution is made containing 1.4410 Gm. of  $VCl_4$  per liter. This unoxidized solution is divided into five equal parts, and to each part is added a graduated amount of the oxidized solution so that the ratios of the volumes of unoxidized to oxidized will be 5/0.9, 5/0.95, 5/1, 5/1.05 and 5/1.1.

Syphilitic Kahn-positive spinal fluid samples and nonsyphilitic Kahn-negative spinal fluid samples are now tested with each of these mixtures in the following manner. On a clean microscope slide pipet 0.05 Ml. of the spinal fluid sample and beside it pipet an equal volume of the mixture being tested. Draw the two liquids together with a small glass rod and mix thoroughly. Allowing the mixture on the slide a minute for reaction, examine it under the low power of the microscope. If there is flocculation, add 0.1 Ml. of distilled water, mix and allow to stand another minute. If the flocculation persists on reexamination, the test is positive. Each mixture of the vanadium solution is tested with at least three positive and three negative spinal fluid samples. One of these mixtures should very clearly differentiate syphilitic and nonsyphilitic spinal fluids. The pH of this sensitive mixture will lie between pH 2.6 and 2.7. Once the ratio of unoxidized to oxidized solution has been determined, it may be used for at least a month without redetermination.

The composition of the precipitates formed in the positive reactions, and the pH at which it is formed have been investigated. These two investigations were carried out simultaneously. A macroscopic test was run, using 3 Ml. of the sample and an equal volume of the reagent. If a precipitate formed, it was centrifuged out and examined, the pH of the supernatant liquid being determined. If there was no precipitate, the pH was taken without the centrifuging. In cases in which there is produced a precipitate soluble in the distilled water added to the microscopic test, we have never been able to obtain any solid material on centrifuging.

The precipitates were examined in numerous ways. First, solubility in dilute acids, bases and salts was tested. All of the precipitates were soluble under these conditions, and none was soluble in distilled water. This is a characteristic behavior of globulin. In appearance the precipitates are gray. Washing repeatedly with distilled water yielded pure white precipitates. These white precipitates left no residue on fusion,

whereas every gray precipitate left a residue identified as  $V_2O_5$ . At least three washings with distilled water were necessary to remove all the vanadium. The results of the pH determinations and of the examinations of the precipitates are given in table 3.

TABLE 3  
RESULTS OF *pH* DETERMINATIONS AND EXAMINATIONS OF THE PRECIPITATES

Total pH determinations.....	70	
Arithmetic mean.....	5.9	pH units
Average deviation of a single determination.....	0.15	pH units
Probable error of a single determination.....	0.13	pH units
Probable error of the mean.....	0.016	pH units
Total precipitates examined.....	24	
Precipitates behaving as globulin (solubility) .....	24	
Precipitates examined for vanadium <sup>1</sup> .....	9	
Precipitates found to contain vanadium.....	9	
Precipitates examined for vanadium by fusion .....	3	
Precipitates found to contain vanadium by fusion <sup>2</sup> .....	3	
Precipitates washed six times with distilled water prior to fusion.....	4	
Precipitates found to contain vanadium after washing.....	0	

<sup>1</sup>Colorimetric qualitative method was used after the addition of water.

<sup>2</sup>Colorimetric qualitative method was used after the solution of the residue in dilute nitric acid.

To determine whether all of the vanadium in the pentavalent state was incorporated in the precipitate, or whether the vanadium found was mechanically included, vanadium determinations were made on the supernatant liquids. They showed a loss of 6 per cent of the total vanadium content. Due to the ratio of 5:1 being used at that time, we knew at least 16 per cent of the total vanadium content was in the pentavalent state. For this reason we decided that vanadium was found in the precipitate because of mechanical inclusion.

Moore, Eagle and Mohr<sup>9</sup> pointed out the incompleteness of research on the effects of other diseases on the tests for syphilis. Perhaps this is because other workers have had experience similar to ours. We were unable to secure spinal fluid from persons with any definite disease other than syphilis. A great part of our material came from the Florida State Hospital, however, and 122 nonsyphilitic samples from mental patients were examined. Two of these samples gave PLV reactions judged positive. The first of these was with sample number 32 and may have been due to an error in technic. At that time it had not been observed that some few samples precipitate albumin, and this fact is easily shown by the addition of water. The second false positive gave

a precipitate identified as globulin. Any number of explanations might be given to account for these false reactions. All would be pure conjecture and, until further work is done, out of place.

The State Board of Health provided us with some 17 samples which had been sent there for complete analysis. Four of these samples contained excess globulin, but the Kahn and PLV reactions were negative on all 17. We may say that not in every case with excess globulin will the PLV reaction be positive.

The spinal fluids examined were divided into three classes. Class 1 fluids were Kahn-positive, syphilitic; class 2 fluids were Kahn-negative, treated syphilitic; and class 3 fluids were Kahn-negative, nonsyphilitic. It is of interest to note that the PLV reaction does not reverse in the spinal fluid as soon as the Kahn and Wassermann reactions. It may be found that this PLV reaction, in its ability to trace treatment further, is of importance, once the diagnosis has been made by standard accepted tests.

The summary of the PLV reactions is given in table 4.

TABLE 4  
SUMMARY OF RESULTS WITH VCl<sub>4</sub> REACTIONS

Total Wassermann- and Kahn-positive syphilitic spinal fluid samples.....	100 (A)
Total Wassermann- and Kahn-negative non-syphilitic spinal fluid samples.....	145 (B)
Total Wassermann- and Kahn-negative treated syphilitic spinal fluid samples.....	101 (C)
Total number of samples .....	346
VCl <sub>4</sub> reaction results with (A).....	98 +, 2 ±
Percentage of disagreement.....	absolute = 2% relative = 0%
VCl <sub>4</sub> reaction results with (B).....	143 —, 2 +
Percentage of disagreement.....	absolute = 1.4% relative = 1.4%
VCl <sub>4</sub> reaction results with (C).....	61 —, 35 +, 5 ±
Percentage of disagreement.....	absolute = 39.9% relative = 39.9%

<sup>1</sup>Bacteria were present.

#### CONCLUSIONS

1. In determining the presence of syphilis, the K<sub>2</sub>Cr<sub>2</sub>O<sub>7</sub>—HNO<sub>3</sub> reaction is too sensitive and at the same time lacking in specificity. It is similar to the reaction proposed by Taccone. From our results (table 1) we are not able to recommend this reaction.

2. The reaction of aqueous VCl<sub>4</sub> solutions with syphilitic spinal fluids has been studied. In an absolute comparison this PLV reaction gives 98.6 per cent agreement with the Kahn reaction. Relatively the PLV and Kahn reactions give 99.1

per cent agreement. These percentages do not include class 2 fluids.

3. A rapid test for syphilis in the spinal fluid has been proposed. A great deal more work, in close cooperation with a large hospital, must be done in order truly to evaluate the reaction.

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#### ADDITION OF VITAMINS TO WHISKY UNDESIRABLE

"Even if it should become legal to add vitamins to alcoholic beverages, physiologic considerations would incline to make such formulas undesirable," The Journal of the American Medical Association for August 7 stated in reference to the stability of vitamins in whisky:

Present government regulations make it illegal to add vitamins to alcoholic beverages. Nevertheless, the fact that many of the diseases associated with chronic alcoholism are due primarily to deficiencies in the vitamin intake of the excessive drinker makes information on the stability of vitamins in whisky of more than academic interest. A. F. Novak and S. L. Adams investigated this question by fortifying a standard brand of 86.8-proof whisky with riboflavin, thiamine and nicotinic acid. Part of the whisky was exposed to daylight in clear bottles and part in amber bottles, and a control portion was stored in the dark. The result of the assays showed that riboflavin is unstable in whisky, since a reduction of 50 per cent of the amount added occurred in both paper-wrapped and amber bottles at the end of the two month period. At the end of six months assays indicated that loss of thiamine or nicotinic acid had not occurred and that these members of the vitamin B complex appear to be stable in whisky.

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**PUBLICATION OF ORIGINAL ARTICLES**

There exists at present a splendid opportunity for members of our Association to have original articles published with less delay than has been possible for many years. Any member who has prepared a scientific manuscript, which has not yet been published, is urged to send it to the editor at Box 1018, Jacksonville 1. If the article is in the process of preparation, this is the time to complete it for early publication in the Journal. There are fewer papers on hand now than at any time during the last ten years.

Several factors are responsible for this dearth of manuscripts. No scientific papers were read by our members at the last annual convention; the district medical meetings were not held last fall; many of our regular contributors are now with the armed forces, and the doctors at home are greatly overworked.

Many splendid papers, which would be of interest to the readers of the Journal, are read at hospital staff meetings. Due credit can be given to the hospital when such articles are published. Other worthy papers are read before county medical societies. The secretaries of county medical societies are urged to send in all papers which they feel would be of interest to the profession at large.

**FACULTY MEETING—DEPARTMENT OF MEDICINE, FLORIDA UNIVERSITY GRADUATE SCHOOL**

The first official meeting of the faculty of the Department of Medicine of the Graduate School of the University of Florida was held in Jacksonville, August 14, 1943, at the George Washington Hotel. Dr. T. Z. Cason, director of the Department, who presided, gave an interesting review of the preliminary work which led to the organization of this new medical Department and the plans for developing it into something of real value to the doctors of Florida.

Under the tentative plan, the Department will be divided into eleven Sections, each headed by a chairman, as follows:

**MEDICAL DEPARTMENT OF UNIVERSITY OF FLORIDA**  
Director, Dr. T. Z. Cason, Jacksonville**SECTION ON ROENTGENOLOGY**  
Chairman, Dr. J. C. Dickinson, Tampa**SECTION ON INTERNAL MEDICINE**  
Chairman, Dr. W. C. Blake, Tampa**SECTION ON PUBLIC HEALTH**  
Chairman, Dr. Henry Hanson, Jacksonville**SECTION ON SURGERY**  
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Chairman, Dr. Shaler Richardson, Jacksonville**SECTION ON UROLOGY**  
Chairman, Dr. Robert B. McIver, Jacksonville**SECTION ON OBSTETRICS**  
Chairman, Dr. S. R. Norris, Jacksonville**SECTION ON GYNECOLOGY**  
Chairman, Dr. Charles J. Collins, Orlando**SECTION ON OTOLARYNGOLOGY**  
Chairman, Dr. H. Marshall Taylor, Jacksonville**SECTION ON PATHOLOGY**  
Chairman, Dr. L. Y. Dyrenforth, Jacksonville

In each Section, a staff of instructors who are diplomates of their specialty boards, will serve with the chairman. The work of the Department will be carried on by the University of Florida, with the cooperation of the Florida Medical Association and the State Board of Health. Dr. T. Z. Cason will be in general charge as director.

Among other things, Dr. Cason requested each Section chairman to prepare a syllabus, appoint instructors and suggest the number of hours required and the time of year best suited

to offer graduate work. He stated that at present there is no set pattern governing the Department of Medicine, as it will of necessity have to be elastic.

The first speaker of the evening was T. M. Simpson, Dean of the Graduate School of the University of Florida. The chair then called on Dr. Eugene Peek, President of the Florida Medical Association, who gave an interesting talk. Dr. John J. Tigert, President of the University of Florida, who was the last scheduled speaker, was enthusiastic in his full endorsement of the plans under way.

The meeting then took the form of a round table discussion with interesting talks by many faculty members. The answers to questions raised clarified many points of the plan and gave those present a much better understanding of the functions of the Department. Attending this meeting were:

*Gainesville:* T. M. Simpson, John J. Tigert. *Jacksonville:* T. Z. Cason, John E. Elmendorf, Jr., Henry Hanson, E. F. Hoffman, Luther W. Holloway, Edward Jelks, Robert B. McIver, Webster Merritt, S. R. Norris, Thomas M. Palmer, Harry A. Peyton, Shaler Richardson, Clayton E. Royce, W. McL. Shaw, E. T. Sellers, H. Marshall Taylor, Stewart Thompson. *Miami:* Homer L. Pearson. *Ocala:* Eugene G. Peek. *Tallahassee:* James H. Pound. *Tampa:* William C. Blake, J. C. Dickinson.



#### MEDICAL LICENSES GRANTED

Dr. W. M. Rowlett, secretary-treasurer of the State Board of Medical Examiners, has reported that out of 82 applicants who took the State Board examination in Jacksonville on June 21 and 22, 1943, 74 were successful in making the general average of 75 per cent and were issued licenses on August 3. There were 8 failures. The names and addresses of the physicians who were issued licenses are as follows:

Anderson, George M., Sanford (La., 1943).  
 Aucremann, Charles E., Atlanta (Emory, 1943).  
 Austin, Dean C., Jacksonville (Washington U., 1942).  
 Blumberg, Bernard M., Pensacola (Tulane, 1942).  
 Bradshaw, Donald G., San Antonio (Chicago, 1943).  
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#### ARMED FORCES MUST HAVE 6,000 MORE PHYSICIANS BY JANUARY 1\*

The armed forces must have 6,000 additional physicians by Jan. 1, 1944, The Journal of the American Medical Association reports in an editorial in its August 7 issue. The Journal says:

At a conference of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians, held on July 31, with the War Participation Committee of the American Medical Association and in the presence of Mr. Paul V. McNutt, chairman of the War Manpower Commission and representatives of the Army and Navy medical departments and the Public Health Service, it became apparent that the medical profession must produce toward the winning of the war an additional six thousand physicians for the armed forces before Jan. 1, 1944. Pursuant to a realization of

\*This editorial is reprinted at the request of the A.M.A.

Fletcher, T. Bert, Jr., Atlanta (Emory, 1943).  
 Flynn, Frederick L., St. Petersburg (Georgetown, 1943).  
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 Geist, Susanne, Miami (Minn., 1942).  
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 Glick, Meyer J., Miami Beach (Detroit, 1925).  
 Gratz, Max, Brooklyn, N. Y. (N. Y., 1932).  
 Haberman, Francis C., Cincinnati (Cincinnati, 1934).  
 Hollowell, Robert D., St. Petersburg (Tenn., 1929).  
 Hood, Douglas W., St. Petersburg (Emory, 1943).  
 Hudson, Charles F., Miami (Va., 1939).  
 Jones, Gerald W., Orlando (Emory, 1943).  
 Jordan, Willis P., Atlanta (Emory, 1943).  
 Kelly, Virgil L., Orlando (Va., 1928).  
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 Kersker, Peter B., St. Petersburg (Cincinnati, 1940).  
 King, William R., Jr., Atlanta (Emory, 1943).  
 Knight, Arthur M., Jr., Jacksonville (Ga., 1943).  
 Kraff, Harry, Miami Beach (Mich., 1934).  
 Lacy, William L., Orlando (Va., 1928).  
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 Shaw, John S., Jr., Coconut Grove (N. Y., 1940).  
 Spoto, Anthony J., Tampa (Tulane, 1943).  
 Steward, William D., Fort Benning, Ga. (Ga., 1936).  
 Sutker, Harold, Atlanta (Emory, 1943).  
 Sutterlin, Frank W., Baltimore (Johns Hopkins, 1939).  
 Temples, Leo G., Camp Blanding (Ga., 1930).  
 Wagenheim, Harry H., Pensacola (Tulane, 1943).  
 Wagnon, George N., Atlanta (Emory, 1943).  
 Watkins, Dayton O., Miami (Md., 1941).  
 Weaver, James M., Miami (Emory, 1943).  
 Webb, Herbert M., Jr., New Orleans (Tulane, 1943).



this objective a directive has gone to the generals in command of the various service commands authorizing them to induct into the service physicians between the ages of 38 and 45 who have been declared available by the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians and who are otherwise subject to Selective Service.

The needs of the armed forces are real. The members of the War Participation Committee raised with the representatives of the various governmental agencies all the questions that have from time to time challenged the need; the challenge seems to have been met effectively. Indeed, the intimation was made clear that the needs of the armed forces will be met by specific regulations of the Selective Service Administration or the enactment of necessary legislation if required. All physicians up to 45 years of age who have been indicated as available have therefore placed on them now the responsibility for an immediate decision as to their enlistment with the armed forces. The need is so positive that questions of essentiality of men in positions of teaching and research and in industrial medicine are likely to be rigidly reviewed in the near future with a view to extracting from civilian life every one that can be spared.

As the war continues and intensifies new needs for the services of the medical profession become apparent. An army in motion and one engaged in the kind of aggressive combat that now concerns our armed forces needs physicians in even greater numbers than have heretofore been demanded. Many thousands of interned aliens and prisoners are now the burden of the United States and must be given medical care.

If there is any physician who still hesitates under these circumstances, he should realize the added advantage to him of accepting now the commission that is proffered. Should it become necessary in the near future, as seems quite likely, to enlist new activity by the Selective Service Administration and the Officers' Procurement Service to bring in the six thousand physicians that are so certainly required, those recruited by that technic will inevitably begin their service with the minimum commission that is offered, namely that of first lieutenant. Until that technic is installed, the men of special competence and of years beyond those of the recent graduate have the assurance of careful consideration and a commission more nearly in accord with age and experience.

The call here made has the approval of the Directing Board of the Procurement and Assignment Service and of the War Participation Committee of the American Medical Association. The medical profession may well be proud of the fact that it has been the only group given, by directive of the President, the responsibility of maintaining service in civilian life and at the same time supplying the needs of the armed forces. Let us not fail in meeting fully the trust that has been placed upon us.

## HOSPITALS SHOULD NOT PRACTICE RADIOLOGY

In an editorial discussing the place of radiology in new forms of hospitalization insurance as well as its place in routine hospital service, The Journal of the American Medical Association for July 31 declares:

Education of the public as to the significance of radiologic practice is important in this direction.

Doubtless few of those who obtain the services of radiology in hospitals realize that in many institutions the radiologist is working for a small salary and the hospital is deriving considerable profit from his professional practice. In other institutions what amounts to virtual fee splitting between the hospital and the radiologist is routine technic.

Certainly it is not to the interest of the patient, who must be given first consideration, that the necessity for radiologic study of his case should be made the occasion for providing excess income for the hospital. If the trend is to be controlled, every new arrangement between a hospital and radiologist and every new plan for a prepaid medical service should be carefully scanned by the county medical society in the area concerned to determine whether or not it violates the fundamental tenets that have been so often iterated and reiterated by the House of Delegates of the American Medical Association.

The danger to the sick does not lie in the collection of income for the hospital or the radiologist; it is in the inevitable deterioration that must come in any form of medical service when its practitioners are placed on a basis in which the quality of the service rendered is secondary to the price charged or the method by which the service is supplied.



## SHALL WE CHANGE OUR FLAG?

State medicine—political control of medical service—always has meant, always will mean, for the mass of people, medical care through and by physicians who are politically amenable rather than by those with superior abilities and skills. That is the opinion of the medical profession and others who oppose the proposal now pending in Congress to socialize medicine under the label of humanitarianism.

The proposal is officially listed as Senate Bill No. 1161. On the surface, it merely provides for the extension of social security legislation. In reality, it is a selfish, ruthless scheme to destroy the liberties of every doctor in the nation. Its implications are terrifying to thoughtful citizens who see in it a precedent that can be used to impose virtual serfdom upon any group whose services may next be demanded, for the avowed purpose of furthering the "general welfare."

If the medical profession can be seized lock, stock, and barrel by government, what about the industries that clothe, house, feed and transport us? All of them are vital. Even the amusement industry is considered essential to the war effort. Why not write a law, seize the works and call it by its right name—communism?

If we want immediate comfort and security badly enough to abandon the basic principles of individual freedom that have made this nation what it is, we should quit pretending to be fighting for democracy and freedom. We are not. We are fighting to be merely comfortable. Instead of the stars and stripes, our standard should be a feather bed emblazoned with a plate of food.

—Industrial News Review.

## DEATHS

Dr. Thomas M. Rivers of Kissimmee died on July 27, 1943.

Dr. John M. Whitfield of Panama City died on August 15, 1943.

Dr. Charles G. Griffin of Miami died on August 24, 1943.

Mrs. Walter A. Weed of Orlando died on August 13, 1943.

Miss Hartley Davis, eight year old daughter of Dr. T. Hartley Davis of Ocala, died on June 27.

STATE NEWS ITEMS

Dr. Arthur Thomas McCormack, Louisville, died of an acute heart attack, Saturday night, August 7. He was born at Howard's Mill in Nelson County, Kentucky, August 21, 1872. Dr. McCormack was State Health Commissioner of Kentucky and Secretary of the Kentucky State Medical Association. He was president of the Southern Medical Association, 1939-1940.

Dr. McCormack succeeded his father, the late Dr. J. N. McCormack, as the State Health Commissioner in 1912. Dr. J. N. McCormack organized the state health work in Kentucky sixty-four years ago and he and his son, Dr. Arthur, were continuously in charge of the State Health Department of Kentucky for those sixty-four years.



Dr. Henry Hanson, State Health Officer, was the guest speaker at a meeting of the Jacksonville Civitan Club, August 20. He gave a brief review of his sixteen years in the tropics, fighting malaria.



Dr. Edward Jelks of Jacksonville attended an all-day meeting of the District Committee of the Procurement and Assignment Service in the Fourth Corps Area, in Atlanta, Ga., August 26. Two other doctors are on this committee: Dr. Edgar H. Greene of Atlanta, chairman, and Dr. Alfred A. Walker of Birmingham. A doctor who is not satisfied with the decision of his state Procurement and Assignment Committee has the right of appeal to this district committee.



Dr. Henry Hanson, State Health Officer, announces the appointment of Dr. Lucille J. Marsh as director of the Bureau of Maternal and Child Health, and Dr. E. J. Teagarden as director of the Bureau of Tuberculosis. Dr. E. F. Hoffman, director of the Bureau of Epidemiology, has been acting director of the Maternal and Child Health Bureau since the resignation of Dr. R. C. Hood last year.



Dr. Gilbert S. Osincup of Orlando, Senior Surgeon, Reserve, of the United States Public Health Service, has been relieved of further duty with the Office of Civilian Defense in Florida as

of August 28. Lieutenant Colonel Osincup will go to Washington, D. C., for duty with the Office of Foreign Relief and Rehabilitation Operations of the State Department. He will be assigned to temporary duty at Charlottesville, Va., under the commanding officer of the School for Military Government. Dr. Osincup, a past president of the State Association and active in organized medicine for many years in the State of Florida, leaves a host of friends who wish him success in the new assignment and will be here to welcome him on his return.



Dr. Leigh F. Robinson of Ft. Lauderdale was appointed chairman of the Health and Housing Division of the State Defense Council to succeed Dr. Gilbert S. Osincup who resigned. Dr. Robinson was appointed by Governor Holland on August 24.



Dr. and Mrs. Harrison G. Palmer of St. Petersburg enjoyed a three-weeks' vacation in Clayton, Ga., during the month of August.



Dr. J. Sudler Hood of Clearwater addressed the local Rotary Club in August. His discussion dealt with diets.



Dr. S. A. Morris of Jacksonville, who has practiced medicine for 55 years, recently retired from practice.



Dr. Meredith Mallory of Orlando addressed the local Chamber of Commerce at one of its weekly meetings in August.



Dr. Edward Jelks of Jacksonville was the guest speaker at a Rotary Club luncheon meeting in St. Augustine on August 15.



Dr. R. J. Shale resigned in August as director of the Hillsborough County Health Department, to accept a position as commissioner of health for the city-county health unit at Helena, Mont.

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**THOMAS MAXIMUS RIVERS**

Dr. Thomas M. Rivers, aged 74, died suddenly at his home Tuesday afternoon, July 27, following a short illness.

Dr. Rivers was born near Lake City, Florida, August 8, 1868, the son of L. W. and Susan (Watson) Rivers, the former a native of South Carolina and the latter of Alabama. After a general education, Dr. Rivers matriculated at the Medical College of South Carolina, from which he was graduated with the class of 1900.

He began his professional career at Lake Park, Georgia, where he continued until in January of 1906 when he came to Kissimmee to establish his practice. The old county trails from Fort Drum to Kissimmee, and from Lake Hart to Davenport, were well traveled by the doctor and his horse and buggy, as he ministered to the sick and unfortunate in the early days of the county, long before the era of the automobile had dawned. In 1913 he pioneered with the first hospital in Osceola County, his practice extending over the entire Kissimmee valley territory.

In addition to his private practice, he contributed his talents in an official capacity. He served as health officer of Kissimmee and of Osceola County for many years. He was a member and former president of the Orange County Medical Society, a member and former president of the Florida Midland Medical Society; he was also a member of the Florida Medical Association, the American Medical Association, the Southern Medical Association, the Florida Railway Surgeons and of the Society of the Atlantic Coast Line. He was the author of numerous scientific articles as well as of a book entitled "The Autonomic Diseases or the Rheumatic Syndrome."

Throughout his career, Dr. Rivers was a public-spirited citizen, contributing generously of his time to the welfare of the community. He was a member of the City Council, a member of the Kissimmee chamber of commerce, Orange Blossom Blue Lodge No. 80, the Free and Accepted Masons, and of the First Christian Church of Kissimmee. During the present conflict, he served as chairman of the health and housing unit under the Osceola County Defense Council.

He is survived by his widow, Mrs. Amy

Rivers; two daughters, Mrs. Herbert Wedewen of Cleveland Heights, Ohio, and Miss Eunice Rivers of Atlanta; two brothers, Bartow Rivers of Orlando and William L. Rivers of Lake City, and four grandchildren.

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**COMPONENT COUNTY SOCIETIES**
**DADE**

Dr. Wiley Sams was principal speaker at a meeting of the Dade County Medical Society held on the evening of August 3 at the Jackson Memorial Hospital. His subject was "The False Positive Serological Report."

**ESCAMBIA**

The Escambia County Medical Society has joined the honor roll of societies whose dues for 1943 are 100 per cent paid. Officers of this society are, Dr. Alvyn W. White, Pensacola, president; Dr. John K. Turberville, Century, vice president; and Dr. Lee Sharp, Pensacola, secretary and treasurer.

**PINELLAS**

By courtesy of the Medical Officers of the Don CeSar Hospital, the regular monthly meeting of the Pinellas County Medical Society was held at that institution on Friday evening, September 3. After dinner, which was served at 7 p. m., the following program was presented by the staff:

1. "Meningococcic Meningitis"—Major Lutterloh; 1st Lt. Vinal.
2. "Atypical Pneumonia"—Major Arneson; Capt. Carl.
3. "Orthopedic Problems in the Army"—Major Pickett.
4. "Surgical Problems Frequently Seen in the Army"—Major Chamberlain.
5. "The Psychoneuroses in Army Practice"—Major French.

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NERVOUS AND MILD MENTAL CASES

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To reach their goal, our Merchant seamen must vigilantly maintain their Victory Ships in proper position in the protective convoy alignment.

It is much the same with the ophthalmic prescriptions you chart — your prescription lenses must be held in proper alignment—in spite of hard knocks and normal careless treatment—if they are to fulfill their responsibility.

The resilient Tri-Flex springs of AO Numont Ful-Vue mountings absorb shocks and return the lenses to balanced alignment. Numont Ful-Vue mountings assure you that your patients will receive the full benefit of your professional correction day after day.

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**ABSTRACT DEPARTMENT**

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville 1, for abstracting in this department.*

URINARY CALCULI IN PREGNANCY; CRITERIA FOR TREATMENT, LOEB, MARTIN J., NEW YORK, UROL. & CUTAN. REV. 46: 495-499 (AUG.) 1942.

The causative factors in the formation of urinary calculus in pregnancy are obstruction, dilatation, stasis, and infection. The principle which should govern the treatment of this condition is that pregnancy is not a contraindication to any operative procedure which may be necessary. The object of any treatment is to improve the condition of the patient so that pregnancy may be continued. In order to achieve this result, one must promote adequate drainage and combat infection.

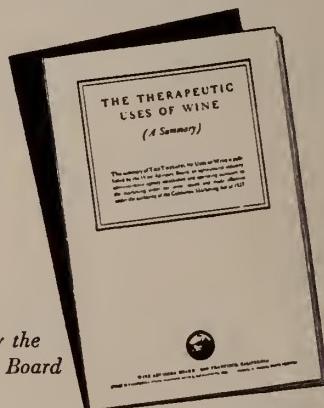
The stasis will best be eliminated by catheterization of the ureters for periods of from six to eight days at a time. The presence of calculi should not interfere with catheterization. Two or three catheters may be inserted at the same time, through which the pelvis of the kidneys may be irrigated several times a day with an antiseptic solution. Stones located at the lower end of the ureter should be removed by meatotomy and instrumentation. In case of impacted stones, when drainage cannot be established, operative procedures must be resorted to. Sulfa drugs may be given to combat infection. Toxemia of pregnancy complicated by calculi should be treated conservatively. If the toxemia is caused by calculous obstruction, drainage must be established by whatever method is preferred.



MASSIVE DESTRUCTION OF THE RIGHT FOREARM AND ARM BY SPINDLE CELL SARCOMA; REPORT OF A CASE, LOEB, MARTIN J., NEW YORK, M. REC., JUNE, 1940.

A 23 year old white boy noticed a lump near his right elbow. He consulted his family physician who made a diagnosis of syphilis and treated him accordingly. This treatment was continued for one and a half years, during which time the arm and forearm became progressively gangrenous and destroyed. The patient finally was referred to the author.

On the right forearm was a gangrenous wound which surrounded the arm and forearm com-

**FACTS DOCTORS SHOULD HAVE ON****THE ACTIONS OF  
WINE**

*Published by the  
Wine Advisory Board*

AN entire generation of physicians lost touch with the medical lore of wine in the United States following the first World War. Actually, however, few other substances have been as widely recommended. This monograph, which summarizes the pertinent scientific literature in the interest that fact be separated from folklore by the application of impartial analysis, will prove of interest and value to specialists in many fields, and to the general practitioner as well.

A section on wine as a food is included. The actions of wine on the gastro-intestinal system, the cardio-vascular system, the genito-urinary system, the nervous system and the muscles, and the respiratory system are discussed. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and convalescent are dealt with. There is a section on the value of wine as a vehicle for medication. Also an important section on the contraindications to the use of wine. Those who wish to pursue the subject further will find an extensive bibliography.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

Members of the medical profession are invited to write for this monograph. Requests should be made to the Wine Advisory Board, 85 Second Street, San Francisco.





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Intramuscular Bismuth therapy is usually well tolerated by patients who react unfavorably or are resistant to arsenicals. It has been found effective

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Special wide mouth ampule, 1 cc.;  
2 gr. (0.13 gm.) in oil.

In boxes of 12, 25 and 100.

Wide mouth bottles, 60 cc.; 100 cc.; 480 cc.

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pletely. The muscles, the olecranon process of the ulna, the head of the radius, the distal end of the humerus were completely destroyed. The appearance of the whole extremity was cadaverous and so was the odor. Physical examination failed to yield other observations of importance. The Wassermann reaction was negative.

The arm was amputated at the surgical neck. Pathologic examination did not disclose anything beyond gangrenous tissue. Five months later the patient returned with a swelling over the lower part of the scapula on the same side. A biopsy revealed a small spindle cell sarcoma. From this one may infer that the original lesion was also a spindle cell sarcoma.

### ADVERTISERS' NOTES

#### CONTINUOUS CAUDAL ANALGESIA IN OBSTETRICS

Eli Lilly and Company, Indianapolis, announces the release of a 16-mm. silent motion picture in color on the subject, "Continuous Caudal Analgesia in Obstetrics." The film is available to physicians for showing before medical societies and hospital staffs. It deals with the history, anatomy, and physiology of caudal analgesia and demonstrates the technic of use in obstetrics.

The film was made at the U. S. Marine Hospital, Staten Island, New York, by authorization of the Surgeon General, U. S. Public Health Service, and the demonstrations were carried out by the originators of the technic, Dr. Robert A. Hingson and Dr. Waldo B. Edwards.

#### PHYSICIANS AS ARTISTS

"From time immemorial, medicine and art have been closely associated. The same skill that makes the surgeon's fingers deft with scalpel and ligature is at work in the beautiful examples of sculpture and carving shown in this book. The eye that so quickly and accurately evaluates the gradations in color and texture between normal and pathologic tissue coordinates the hand that wields the painter's brush. The man who chooses medicine as his life's work is largely motivated by a love for his fellow man, else he would select a vocation offering greater monetary reward. From the beginning, he is trained to exercise his powers of observation, and in time develops imagination, sympathy, understanding, philosophy and reverence, all of which are the very essence of art. Moreover, he deals with that most exquisite form of divine art and beauty, the human body."

"An artist-physician has said: 'The tendency of most persons is to regard the artist with awe as a superman endowed with talents not vouchsafed to the ordinary mortal. Most doctors have a latent artistic sense which may be developed to a remarkable degree by constant practice. When opportunity affords, slip away to the park or country, sit down on a camp-stool and practice sketching from nature. At first the results may not be satisfying, but in course of time you will be gratified to notice a marked improvement. An ample sketching kit may be purchased for a small sum and any local artist will be glad to give you instruction.'

"At the least, every physician is able to develop a sensitiveness to and an appreciation for fine art. He can also cultivate a hobby, which, if not one of the fine arts, is in the class of 'work by the side of work.' Dr. Charles A. Dana, who has always stressed the value of cultural medicine, has advised: 'Be a collector, for ex-



**F**OR supplying Mercurochrome and other drugs, diagnostic solutions and testing equipment required by the Armed Forces, for developing and producing Sterile Shaker Packages of Crystalline Sulfanilamide especially designed to meet military needs, and for completing deliveries ahead of contract schedule—these are the reasons for the Army-Navy "E" Award to our organization. The effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use.

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HERE's Ed all grins over his first home-grown tomato. Sure, it's a little on the midget side. And it is kind of green on top.

Not much of a tomato, really . . . but to Ed it's one of those little things that somehow mean so much these days to all of us.

Raising your own Victory Garden . . . settling down with your favorite newspaper . . . calling on a new neighbor . . .

Sure, they're just *little* privileges, simple pleasures but they make you feel *good* inside. They boost the old morale.

\* \* \*

It happens that millions of Americans attach a special value to their right to

enjoy a refreshing glass of beer . . . in the company of good friends . . . with wholesome American food . . . as a beverage of moderation after a good day's work.

A glass of beer—a small thing, surely—not of crucial importance to any of us. And yet—morale is a lot of little things like this.

Little things that help to lift the spirit, keep up the courage. Little things that are part and parcel of our own American way of life.

And, after all, aren't they among the things we fight for?

## MORALE IS A LOT OF LITTLE THINGS

(*as you, Doctor, know better than most*)



ample, of stamps or automobiles, or old books, or neckties, or pins; or find diversion in some collateral branch of science; the love of birds, of fishing and shooting. Make a garden or cultivate shrubs and flowers. These kinds of activities will make your life happier and your professional character more attractive and effective."

—Quoted from "Parergon," published by Mead Johnson & Company, Evansville, Ind. Free copy available to physicians on request.

#### PENICILLIN BIBLIOGRAPHY

Announced in the June issue of Medical Journal Abstracts, the very complete 93-page annotated bibliography, Penicillin and Other Antibiotics Produced by Microorganisms, published by E. R. Squibb & Sons, has had widespread distribution, both to physicians in civilian practice as well as to those with our armed forces. It is distributed, as an editorial addendum states, "with the hope that in the interim all in medical practice who are interested in Penicillin may have an opportunity to post themselves on the preliminary investigation which preceded its general accessibility."

The bibliography is divided into three parts. The first portion, containing abstracts of 105 papers, deals with Penicillin, and since the arrangement is chronological the historically-minded reader can follow investigational progress from Fleming's announcement of his discovery in 1929 up to the clinical report of Mayo Clinic's Doctors Herrell, Cook and Thompson in the May 29, 1943 issue of the J. A. M. A.

The second part of the bibliography contains 124 papers dealing with Tyrothricin and Other Antibiotics from Bacteria. The third section includes 20 references to Antibiotics from Various Organisms and to reviews of all these subjects. The utility of the bibliography is measurably enhanced by a very detailed author and subject index. The publishers announce copies are available gratis to physicians; address Professional Service Department, E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

#### NONREFLECTING GLASS

Non-reflecting eyeglasses and windshields, the latter lessening the possibility of auto accidents, are made possible by a new method for taking light reflections out of glass and other materials, H. R. Moulton, assistant research director of the American Optical Company, announced recently.

For the first time large areas of glass and other light-reflecting materials can be made nonreflecting by the new surfacing treatment. Previous methods of removing such reflected light were limited to relatively small pieces of such materials. The new surfacing technique also increases the durability of the treated substance and at the same time does not damage the original surface.

Untreated ordinary glass transmits about 92 per cent of light, the remaining 8 per cent being lost through surface reflections. Much of this lost light is saved by the new reflection remover.

The new development is considered a military secret and its chemical composition, method of application, and military uses cannot be revealed at the present time. Emphasizing that the discovery is now being devoted exclusively to war purposes, Mr. Moulton revealed some of its possible postwar applications, as follows:

Possibility of auto accidents will be lessened by surfacing windshields to reduce light reflections which are potentially dangerous because of their blinding effect on eyes.

Spectacle lenses will become less conspicuous through a reduction of light reflections, and annoying reflections of bright lights in the glasses, as seen by the wearer, will be greatly reduced.

Greater visibility for auto dashboards and airplane instrument panels may be obtained by reducing light reflections.

Show windows and cases treated by the new technique will be free from disturbing reflections, and the contents accordingly seen to better advantage. The glass itself will seem invisible.

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### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY, Issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association.

Through the years the size of this volume has grown with the increased work of the Council on Pharmacy and Chemistry until the present edition has the same number of pages as the book published in 1908, which covered the Council's first four years of activity. Some of the functions of this group are well known, but a more thorough understanding of the Council's scope may be gained from the annual reprint. This volume epitomizes that phase of the Council's work which may be said to be collateral to the "acceptance" of drugs,—the informative consideration of current medical problems in the interest of rational therapeutics. It contains reports of studies by private investigators which were originally published in The Journal under the sponsorship of the Council such as preliminary discussions of new developments in therapeutics and timely articles on the status of recognized agents as well as reports of omission or rejection of products from New and Nonofficial Remedies. It also offers a record of current decisions on matters of Council policy.

Several of the reports are of particular interest for various branches of medical science: the use of bulk ether in anesthesia, the absorption of surgical gut (catgut), the higher types of antipneumococcus rabbit serum, the surgical and medical treatment of animals with experimental hypertension and the status of racemic epinephrine solutions for oral administration. The reports in this small compact volume represent expert medical consensus and are proffered to aid in the consideration of the value of therapeutic agents.

Cloth. Price, \$1.00. Pp. 207. Chicago: American Medical Association, 1943.

THE BOY SEX OFFENDER AND HIS LATER CAREER. By Lewis J. Doshay, M. D., Ph. D., Psychiatrist, Children's Courts, New York City. From an experience of ten years of daily work in handling problems of juvenile delinquency, the author charts the salient factors of environment and personal makeup that produce the boy sex offender and determine his later career. The study outlines objective criteria for prediction of the adult outcomes. The figures of the study are derived from carefully checked court records. Cloth. Price, \$3.50. Pp. 206, with 52 illustrations. New York City: Grune & Stratton, 1943.

REHABILITATION OF THE WAR INJURED. A symposium edited by William Brown Doherty, M. D., and Dagobert D. Runes, Ph. D. Cloth. Price, \$10.00. Pp. 584, with illustrations. New York: Philosophical Library, Inc., 1943.



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## STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association .....	Eugene G. Peek, Ocala .....	Shaler Richardson, Jacksonville.....	To Be Announced
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna L. Y. Dyrenforth, Jacksonville.....	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	" " "	" " "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach.....	" " "	Miami, Postponed
Alabama Medical Association .....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg.....	Kenneth Phillips, Miami.....	To Be Announced
Dental Society, State.....	A. Malcolm Smith, D.D.S., Tampa.....	H. L. Cartee, D.D.S., Miami.....	Jacksonville, Nov. 10, 11, 1943
Derm. and Syph., Soc. of.....	Wiley M. Sams, Miami.....	Lauren M. Sompayrac, Jacksonville.....	Miami, Octoher, 1943
East Coast Medical Association .....	T. C. Kenaston, Cocoa.....	I. M. Hay, Melbourne.....	Postponed
Hospital Association.....	Mr. W. E. Arnold, Jacksonville .....	Miss Katharine Moyer, Lake Wales.....	
Industrial Surgeons, Assn. of .....	Frank D. Gray, Orlando.....	Richard H. Walker, Orlando.....	To Be Announced
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville.....	Chairman	
Nurses Association, State.....	Mrs. Ann Thompkins, Leesburg.....	Miss Madalee Hazel, St. Petersburg.....	
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville.....	C. E. Dunaway, Miami.....	To Be Announced
Pathological Society.....	L. Y. Dyrenforth, Jacksonville.....	Iva C. Youmans, Miami.....	To Be Announced
Pediatric Society.....	Ludo von Meysenbug, Daytona B.....	Robert Blessing, Ft. Lauderdale.....	To Be Announced
Pharmaceutical Association, State .....	Mr. H. B. Douglas, Bonifay.....	Mr. R. Q. Richards, Ft. Myers.....	Miami, To Be Announced
Public Health Association .....	Leland H. Dame, Sanford .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	John N. Moore, Ocala.....	Walter A. Weed, Orlando.....	To Be Announced
Railway Surgeons' Association .....	Frank D. Gray, Orlando.....	W. C. Page, Cocoa .....	To Be Announced
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales .....	Mrs. May Pynchon, Jacksonville .....	To Be Announced
Chattahoochee Valley Med. Assn.....	Herhert E. White, St. Augustine .....	Robert B. McIver, Jacksonville .....	Postponed
Gulf Coast Clinical Society.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	Postponed
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola .....	Kenneth Phillips, Miami.....	
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta.....	Postponed
Southern Medical Association.....	Harvey F. Garrison, Jackson, Miss.....	Mr. C. P. Loranz, Birmingham .....	Cincinnati, Nov. 16-18, 1943
Suwannee River Medical Society .....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City.....	



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Vol. XXX

NOVEMBER, 1943

No. 5

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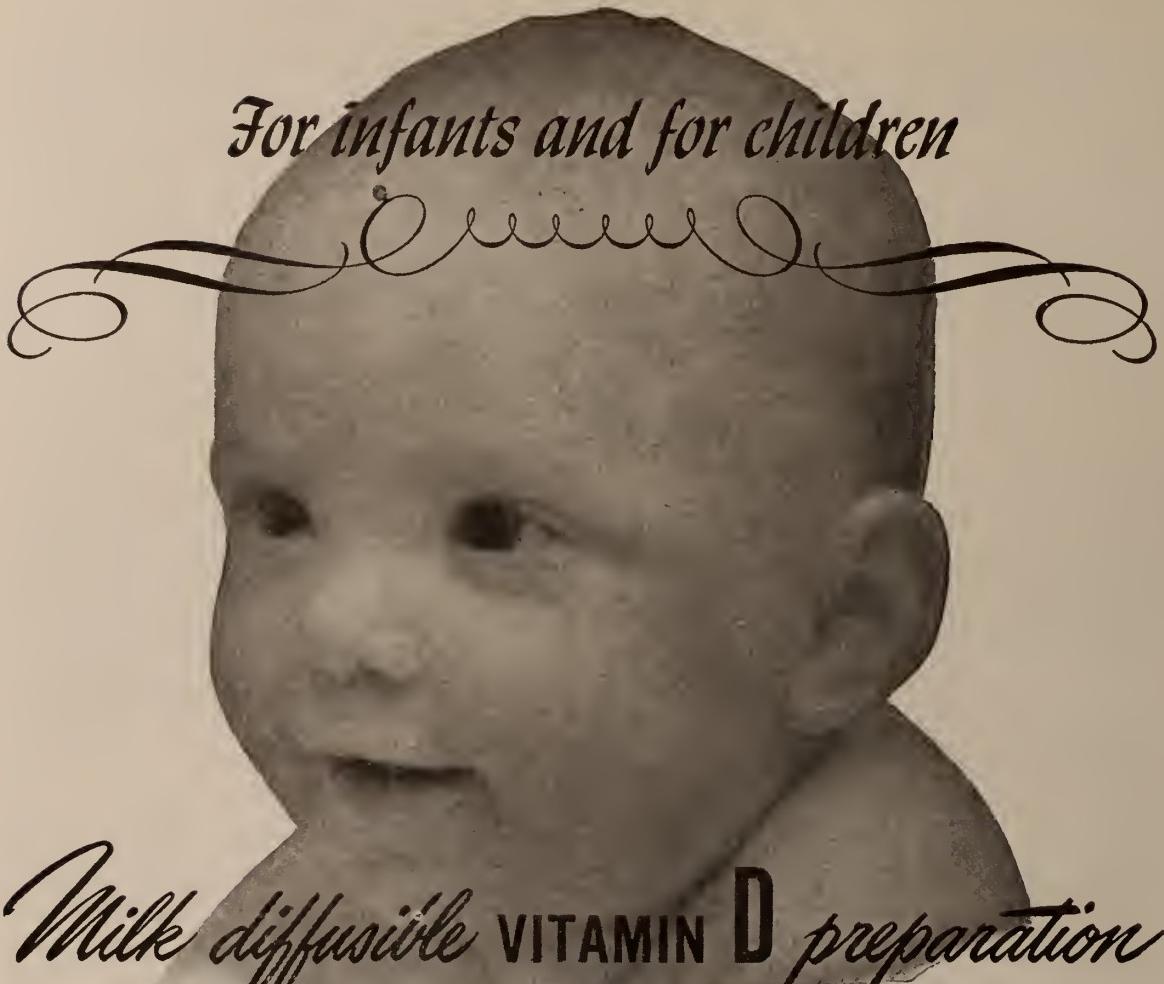
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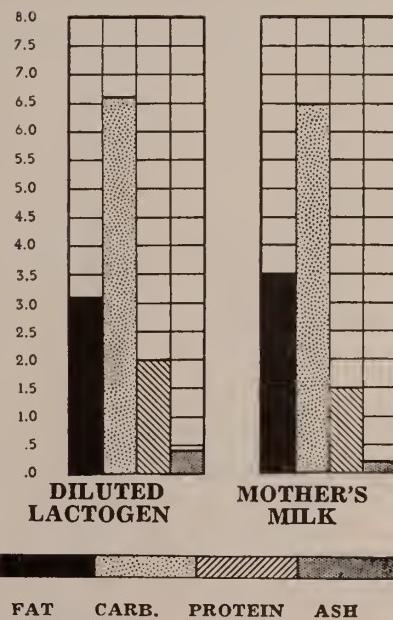
The image shows a close-up of a baby's face and upper body. The baby is lying on its back with its arms raised and hands clasped together above its head. The baby has dark hair and is wearing a light-colored onesie. To the right of the baby is a cylindrical can of Lactogen infant formula. The can has a label that reads "LACTOGEN" in large letters, "NESTLÉ" below it, and "DRYED COWS' MILK" at the bottom. There is also a small emblem on the can that says "ACCEPTED AMERICAN MEDICAL ASSN".

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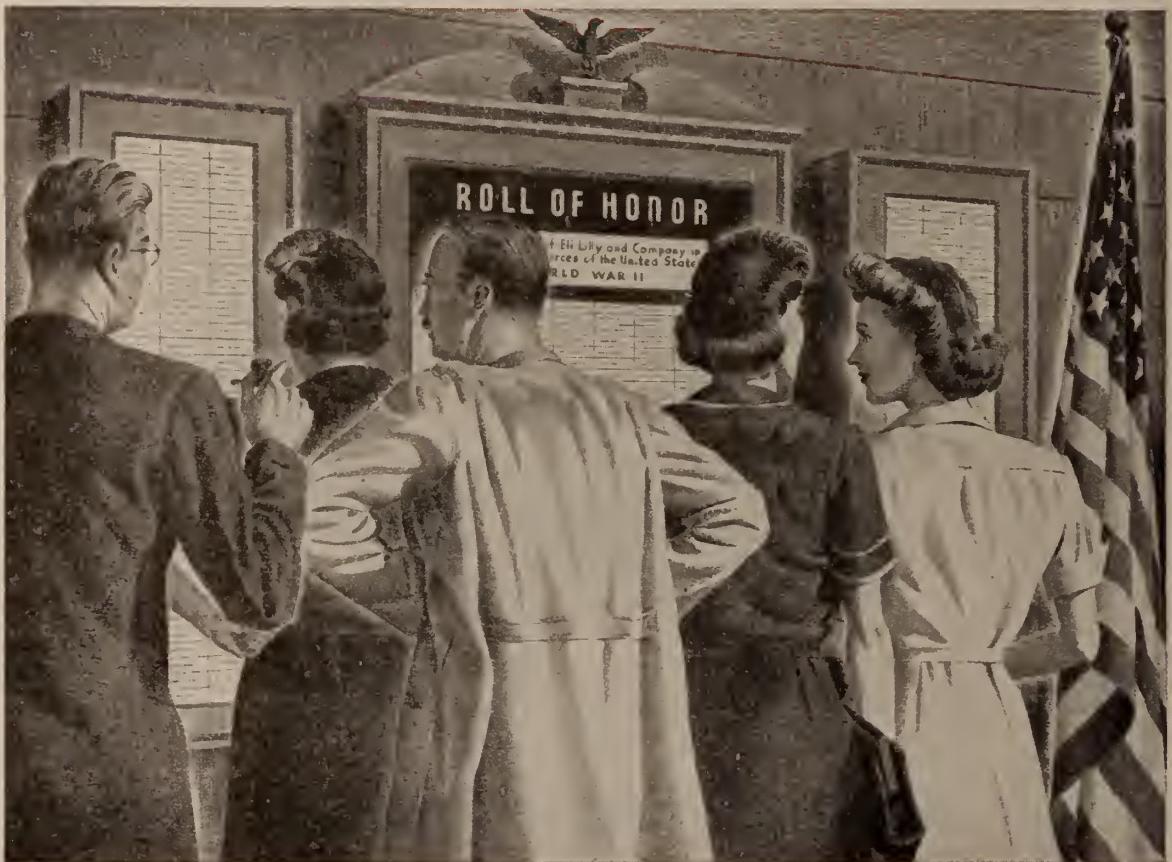
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## TREATMENT OF ACUTE AND CHRONIC TRAUMATIC TEMPOROMANDIBULAR

### ARTHRITIS

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CHICAGO

Pain, a factor in the complex of symptoms associated with subluxating joints will, as a rule, make a person seek relief. The discomfort is one that may also be associated with other diseases, and therefore a correct diagnosis is not always made. The peculiarity of the joint and its relation with other important structures make misinterpretation easy and frequent. Only within recent years have a few authors written about diseases of the temporomandibular joint.

This joint is a bilateral condyloid articulation permitting motion in all directions except axial rotation. It differs too from other joints in that it hangs loosely in its ligaments when at rest. Normally the head of the condyle moves in the glenoid fossa, and when the mouth is opened widely, it moves out onto the eminentia articularis. If the joint is subjected to sudden violence, especially when the jaws are widely separated, the condyle may pass the eminentia articularis and slip forward through the articular ligaments into the zygomatic fossa. Such a displacement constitutes a dislocation which, therefore, is always forward. A dislocation may also occur by external violence when the mouth is closed, though that occurrence is rare. Also, in yawning it may be produced by muscular spasm. A complete dislocation unreduced is easily recognized by the deformity it causes.

Subluxation may be defined as a self-reducing incomplete dislocation. It was first described by Sir Astley Cooper, who attributed it to relaxed ligaments permitting excessive motion of the bone. In such cases this condition may be accompanied by some displacement of the meniscus. Complete dislocation and subluxation often are associated with traumatic arthritis, which occurs also in cases of external violence not resulting in either dislocation or subluxation. These cases are usually

characterized by pain and yield a history of the trauma.

Other forms of arthritis of this joint may be due to infection from the ear to which it is closely related and may cause ankylosis. In children arthritis may follow the exanthemas while in adults it may be one of the sequels of some constitutional disease such as rheumatism, gout, or gonorrhea.

The various lesions mentioned have been described briefly so as to define more clearly the group of patients to be treated by injection. The injection treatment herein discussed is confined to this type of subluxated joint. Our experience has been largely confined to subluxation of the temporomandibular joint; the results have been very satisfactory. A sufficient number of joints elsewhere in the body has been injected to prove that this type of treatment is of value in other joints having relaxed capsules and ligaments. Callahan,<sup>1</sup> Smith and Johnson,<sup>2</sup> Chandler,<sup>3</sup> Turek,<sup>4</sup> Salman,<sup>5</sup> Moose,<sup>6</sup> Thoma<sup>7</sup> and others have used it successfully in various joints such as those of the fingers, hips and knees, and the sacroiliac joint. The treatment of joints other than the temporomandibular is essentially the same as that outlined in this report. Possibly a larger quantity of the mixture should be injected, the amount varying perhaps with the cubic capacity of the joint cavity.

### ETIOLOGY

Subluxating joints are not rare. The relative frequency is readily explained by the numerous etiologic factors. Many persons have such lax ligaments about their joints that even slight violence may result in subluxation. Opening the mouth widely as in yawning may produce subluxation; so may a forcible or too long continued opening as during the extraction of teeth. Especially does this contingency apply when nitrous oxide and a mouth gag are used. Injudicious opening of the mouth under ether anesthesia may have a similar result. In such cases the ligaments are stretched beyond their normal limits of elasticity and are torn. They do not usually recover unless or until adequately treated. The best results are obtained if treatment is applied as quickly as possible after the luxation or subluxation. If during an ether anesthesia the patient has difficulty in breathing and the anesthetist

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Fig. 1. This microphotograph represents a normal untreated joint. The cartilaginous semicalcified bone is at (B). The perichondrium (P) is enclosed in a fatty capsule (C), which is permeated by narrow strands of fibrous tissue (F). The latter give support to the capsule, and it is upon this region that the solution produces reaction.

holds the lower jaw upward and forward to make respiration easier, the lower jaw may subluxate or even dislocate. In some cases positional pressure, as sleeping on the arm, may cause the disturbance by forcing the jaw to the opposite side.

#### SYMPOTMS

The deformity of complete dislocation can be seen, for usually the mouth is opened and cannot be closed by the patient; it may likewise be felt with the palpating finger. Locking of the jaws may occur, when they are both open and closed in luxation or in subluxation. The meniscus or fibrocartilaginous disk is usually responsible for this condition. In such cases it is caught and folded between the head of the condyle and the eminentia articularis. A symptom of subluxation particularly annoying to the person affected and to others present is the click. This clicking or a grating sensation, or both, may be audible many feet away and may be the cause of embarrassment. Fortunately it is readily amenable to treatment.

Inspection reveals the head of the condyle coming out of the glenoid fossa on opening the

mouth. The palpating finger now falls into the joint cavity vacated by the condyle. Clicking may occur during any one of three phases; first, on opening; second, on closing; and third, on the exertion of pressure when the patient is chewing. In addition, there is pain when the joint is moved on opening or closing.

#### DIAGNOSIS

The diagnosis of subluxation is easy. The symptoms as enumerated are characteristic, but accompanying them there should always be a good history. The indications for treatment are plain. To recapitulate, they are (1) pain, remote or local; (2) luxation or subluxation; (3) a clicking or grating noise, or both; (4) locking of the mouth in either the open or closed position, and (5) mental complex of fear. Unilateral subluxation should be treated bilaterally to balance the action of the jaw. A normal joint with a mate having excessive motion will frequently become similarly affected, and clicking, pain, or even locking may occur on both sides. The contraindication for treatment is excessive motion without pain, clicking, grating, or locking. Normal

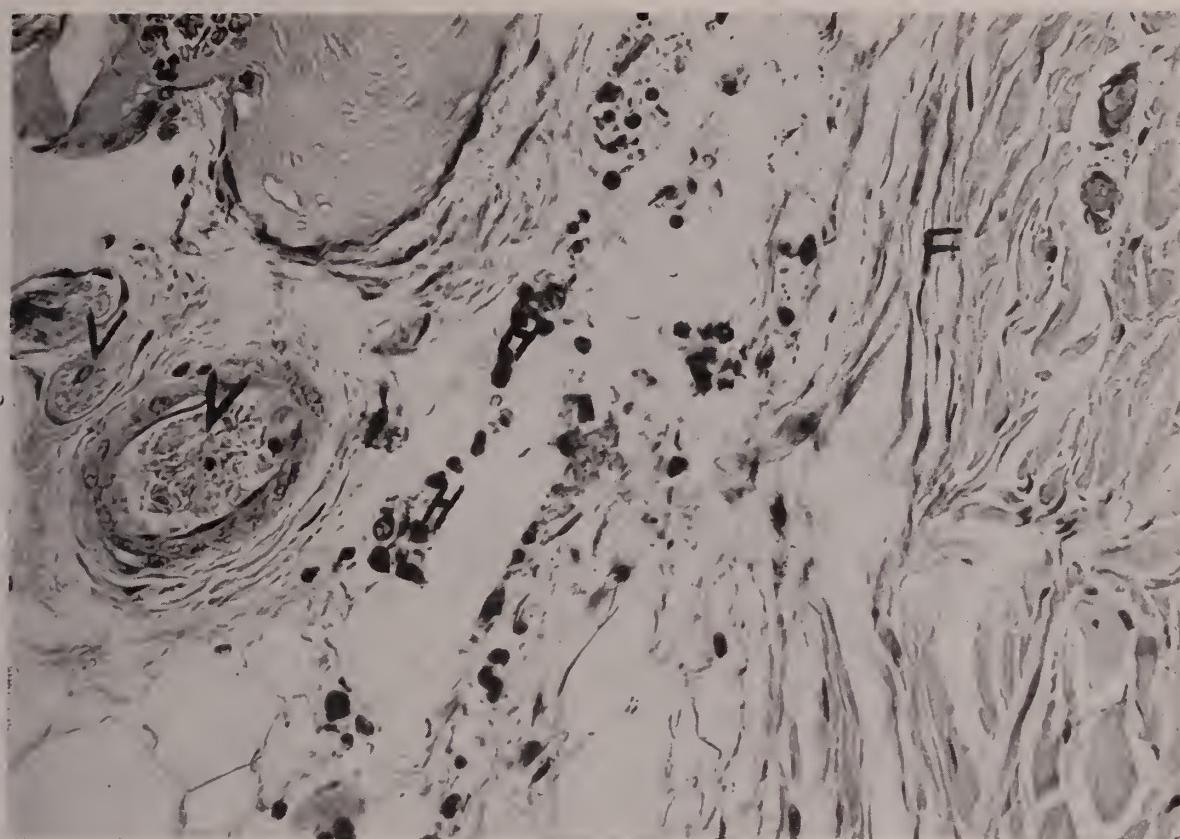


Fig. 2 Illustration of a treated joint under high power magnification. The primary reaction consists of a proliferation of young vascular channels and histiocytes with subsequent change of the latter to fibroblasts and older connective tissue. At (F) is shown part of a fibrous strand in the capsular fat; young vascular channels (V. V.) with proliferating histiocytes and round cells are seen at (H). This high power field is supplemented by figure 3.

motion of one joint and excessive motion of the other joint require treatment of the hypermobile joint only.

#### TREATMENT

Various types of treatment applied in the past and still used by some operators appear to be unsatisfactory. Surgery is one of them. Among the disadvantages and dangers accompanying surgery are resultant scars; in addition, the physical difficulties of removing the cartilaginous disk are rather great. Scarcely less formidable is the method of placing mattress sutures in the capsule. Other complications relevant to surgical methods of attempting relief are possible; they include facial paralysis on the side operated on, and a permanent salivary fistula if the parotid gland is injured. Then too, the close proximity of the external maxillary artery adds to the hazards. Last but not least, an ankylosis may result, due particularly to an infection incident to the operation.

About four years ago one of us, (L. W. S.) instituted a conservative treatment of subluxation of the temporomandibular joint because of the numerous disadvantages encountered in the operative therapy. Prominent in the literature

then was the attempt to cure hernia and varicose veins by the injection of some sclerosing agent. The assumption seemed logical that injecting such an agent into or about the joint could cause sufficient thickening of the related capsule to prevent a recurrence. Experimental work was conducted to determine if the resultant fibrosis and shortening of the ligaments would stabilize the joint without exerting a deleterious effect upon the motion of the joint or upon its cartilaginous surface. With the assistance of one of us (W. S.), experiments were conducted on the joints of dogs, cats, rabbits and guinea pigs in the hope of finding an agent which would produce a maximum amount of fibrosis and meet the requirements mentioned. After numerous trials in which various solutions were used, we finally selected sodium psylliate (sylnasol). Histologic examination of the cartilaginous surfaces of the joints previously injected showed no inflammatory reaction.

A review of some methods of treatment in use shows a modicum of good in all, although most are quite unsatisfactory. A method commonly used, but likewise unsatisfactory, consists of putting a bandage around the head fixing the



Fig. 3. This microphotograph is a supplement to figure 2. It shows a considerable amount of replacement of the fatty capsule (C) by large strands of fibrous tissue (F). The whole has been replaced by moderately dense fibrous tissue throughout which numerous "reaction" areas remain (R). The round and histiocytic cells and vascular channels are evidence of continued proliferation (V). In no areas were foreign body giant cells seen. Also, as noted, there is evidence of continued or unfinished reaction (R).

mandible to the superior maxilla and instructing the patient not to open his mouth for large morsels of food, but to keep the joint at rest. This may serve as a diagnostic aid in doubtful cases when pain is the only symptom present, because a period of rest will relieve the pain.

Costen's treatment<sup>8</sup> for a malfunctioning temporomandibular joint associated with neuralgia or deafness, or both, consists of causing a change of relationship in that joint by repositioning and readjusting the dental arches. Its main feature consists of causing a slight increase in the vertical dimension of such a joint. This treatment is helpful in some cases, but not always curative.

The treatment recommended by the authors consists of putting a few injections of a sclerosing agent into the cavity of the joint. This measure tightens the capsule. The injection is usually made on both sides, after a careful physical examination of the joints and their movements. Naturally a good history, the results of careful inspection of the external auditory meatus and the bite of the teeth, and the time of the click, if present, are recorded. To facilitate accuracy, a 1 cc. tuberculin syringe is filled with the solution to be

injected, and a 26 gauge needle 1½ inches long is adjusted. The skin over the joint is rubbed briskly with an alcohol sponge; the tip of the index finger of the left hand is dipped in alcohol and used to palpate the structures over the joint. The patient is then asked to open the mouth until the head of the condyle leaves the glenoid fossa. Then the needle is inserted inward, forward and upward into this cavity till it strikes the inner table of bone at a depth of from 2 to 3 cm. The needle is withdrawn about ½ cm. and 6 to 8 drops of a modified solution of sodium psylliate is injected. This procedure is repeated on the opposite side.

Both temporomandibular joints should be injected even though the clicking or grating may be present on one side only. The injections should be repeated every 2 or 3 weeks till sufficient fibrosis has developed to effect a cure. In some cases there is need for but one injection while in others as many as from four to six may be required. The second or third injection is much harder to make because the head of the condyle now is in close apposition to the glenoid fossa and does not leave it when the mouth is open.

Patients suffering most from pain, subluxation and clicking usually obtain the best results; likewise it is true that relief is more prominently obtained in patients sustaining the greatest degree of local reaction after injection.

It is well to know what reaction may be expected. From twenty to thirty minutes after the injection has been given, there may be discomfort, and for this reason we always give 10 or 15 grains of aspirin at the time of the injection with instructions to the patient to take more later if necessary. Only in 2 out of the first 180 cases in which we used sodium psylliate was an opiate necessary. But satisfaction to us lay in a treatment leaving the patient free from discomforts. After much experimentation we improved the remedy and now use an oil and an aqueous solution, equal parts of which are mixed when used and converted into an emulsion by violent shaking. A 0.2 per cent solution of eucupine in oil\* and a 5 per cent aqueous solution of sodium psylliate\*\* are mixed by extracting them in equal parts with the hypodermic syringe through the rubber stopper of the bottles. We inject 6 to 8 minims of this mixture into each temporomandibular joint. These solutions must be mixed fresh or they will lose their potency. This precaution makes the treatment practically painless.

The injection itself should not produce more discomfort than the prick of the needle followed by a slight feeling of fullness in the joint. The needle is inserted as described to the inner table of bone, or to a depth of about 2 or 3 cm. It is then withdrawn about  $\frac{1}{2}$  cm., and a gentle pull on the piston demonstrates whether or not the end of the needle is in a blood vessel; if so, another like withdrawal is made, and the test is repeated. When no blood appears, the emulsion described is injected into the cavity of the joint. It is important that this test should be made to make sure that the emulsion does not enter a blood vessel. Being oily, it would be dangerous and might even be fatal if injected directly into the blood stream. In the majority of the cases the patient has no complaint other than some interference with chewing for the remainder of the day on which the injection is given. The administration of 10 grains of aspirin may occasionally be necessary to keep the patient comfortable. The emulsion described is just as effective as the original solution except that a

slight feeling of numbness of the side of the face may be noticed due to the anesthetic action of the oily solution.

There may be swelling in the region injected, which usually lasts three or four days. The bite of the teeth may be temporarily shifted slightly forward and downward or to one side, depending on the degree of the reaction. The molar teeth may not come into occlusion because of the thickening of the capsule; this effect is likewise temporary. Very rarely there is salivation for from twenty-four to forty-eight hours with some pain.

The reason for failure of this method of treatment is primarily that the injection is not made in the proper place, as, for instance, when it is made into a blood vessel rather than into the cavity of the joint, or when made into the periarticular tissue rather than into the intraarticular cavity; likewise an injection into the middle ear or into the external auditory canal would not help the joint. This reason for failure is, however, true of all injections anywhere in the body.

#### CONCLUSION

This paper is submitted for publication to give the profession a clearer conception of the treatment described including its progress, soundness and efficacy. This subject was the basis of an article by one of us (L. W. S.), published in the *Journal of the American Medical Association*, September 25, 1937.\* We have treated over 200 cases to date, and this report is more valuable in proportion to the larger experience gained.

We direct attention to the simplicity and the safety of the treatment, also to the fact that the procedure is adaptable to other joints in which function is impaired by lax ligaments. As demonstrated in figures 1, 2 and 3, it is concluded that there is positive histologic evidence of fibrosis of the capsule of joints injected with this sclerosing compound. Further experimental work, now going on, is necessary to render this treatment entirely painless.

We wish to extend credit to L. J. Rossiter, who kindly assisted with the microscopic data.

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## HEADACHE

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The symptom of headache is present in so many physical disturbances and is often so disturbing to the sufferer that medical aid is sought to relieve it. In giving relief one must not overlook the importance of headache as a symptom and should always seek the underlying cause.

Anatomically there are only certain areas within the skull where pain can be produced. These are chiefly in the prolongations of the dura along the peripheral blood vessels and large venous sinuses of the brain. Fibers from branches of the fifth nerve and the vagus and their connections with the sympathetic network around the cranial blood-vascular system are the mediums through which pain is felt.

Conditions which cause these sensory fibers to be subjected to tension or irritation give rise to headache. This occurs through variations of pressure on the walls of the vessels by congestion, increase or decrease of the fluid volume within the blood vessels or venous sinuses, by edema or hemorrhage in the tissues surrounding them and from the effects of toxins or chemical agents such as histamine and amyl nitrite. Hypertensive conditions, allergies, hormonal disturbances and emotional upsets are other causes. Lowering of the content of the blood vessels produces a similar result, in which instance the ventricles become overfull. Tumors may produce pain in the head by direct pressure, or by making traction on the cerebral vessels.

In the main, headaches are due to variations in the action of the sympathetic and parasympathetic nervous systems, either by direct or by reflex stimulation. The latter may occur as a result of gastrointestinal or renal conditions, or

from infections located at points remote from the skull.

Headache is a prominent symptom in most acute febrile conditions. Dull persistent frontal headache is one of the earliest complaints in typhoid fever. Acute toxemias are usually ushered in by a more or less severe headache. This symptom is common in diseases of the kidney and occurs frequently in hypertensive conditions and in arteriosclerosis. It may indicate anything from simple hysteria, an impacted wisdom tooth or an acute sinus affection to meningitis, carbon monoxide poisoning or a tumor of the brain.

The pain from acute frontal or maxillary sinusitis is usually felt in the area of the sinus involved or over the forehead. It is intensified by coughing, stooping or straining and by pressure over the area. In ethmoid sinusitis it may be felt behind the eyes or over the brow, and in acute sphenoidal affections it is usually felt more deeply behind the eyes, or is referred to the vertex. The pain is worse in the morning, tending to wear off after the person is up and about, or when drainage is established. This type of headache is in contradistinction to that from eyestrain, which comes on later in the day after use of the eyes. Also, in sinus conditions there are present the characteristic nasal symptoms of blockage and discharge, and usually there is a history of a recent head cold. That headaches may be due to pressure on the sensitive nervous mechanism within the nose from enlarged turbinates, polyps or septal deviations and spurs, or to sphenopalatine neuralgia must be kept in mind. This type of neuralgia may have a wide radiation about the head and may be referred to the ear or neck. It is usually unilateral and is relieved promptly by anesthetizing the sphenopalatine ganglion intranasally. This measure also serves as a diagnostic test. Headaches from most ocular and nasal conditions are of the congestive type because of stimulation of the sympathetic nerves. Those from aural conditions may occur similarly, or by direct extension of infection to the meninges.

Headaches are associated with most acute inflammatory affections of the eyeball, such as uveitis, iritis and glaucoma, also orbital cellulitis, periostitis and osteomyelitis, each condition being recognized by its distinguishing characteristics. It is important that these diseases, especially glaucoma, should be accurately diagnosed as the treat-

ment so helpful, for instance, in iritis or uveitis would be disastrous in glaucoma.

Various noninflammatory conditions of the eye often produce headache. They include errors of refraction, spasm of accommodation, muscle imbalance and aniseikonia. Because an uncorrected refractive error exists in a given case, it does not necessarily follow that the headache of which the patient complains is due to that, and the prescribing of glasses alone may not cure it. Many a patient has been fitted with glasses, or given a series of eye exercises, and the fact that he also needed a submucous resection of a badly deviated nasal septum, an infraction of enlarged cystic middle turbinates, the removal of infected tonsils, or probably extraction of an impacted wisdom tooth was entirely overlooked.

Ocular affections may be so linked up with the patient's general condition or with some important local pathologic change that a knowledge of general medicine, on the part of the examiner, is essential in order adequately to meet the required exactitudes of diagnosis and treatment. Observant physicians recognize this fact in referring their patients to the oculist. It is to be regretted, however, that many practitioners through laxity or indifference, or for some reason, are still content to let nonmedical persons pass judgment on and direct treatment of the ocular conditions of their patients instead of asking their properly qualified medical colleagues to do so. They seem to have overlooked the importance to the patients and themselves of the ophthalmologist's medical background in properly evaluating these cases.

Not all headaches are intracranial in origin. They occur from myalgia of the muscles of the scalp, as a result frequently of overaction of the extrinsic muscles of the eye, or from neuralgia of the nerves of the scalp. The pain may be referred to the superficial structures of the head from viscera in the thorax or abdomen through the vagus and trigeminal nerves. Aching in the occipital and cervical regions may be the result of a compensatory tilting of the head in muscle imbalance, especially hypophoria.

It is more or less simple to find the source of the headache in acute sinus and other definitely localized conditions, but not so easy in those with less familiar signposts. Headache from an overloaded intestine is considered due to reflex action through the sympathetic nervous system rather than to toxic absorption, since it is relieved promptly by emptying the bowel.

Headache from endocrine disturbances may be by reflex action on the vascular system of the meninges due to variations in the adrenalin and pituitary output, or by direct action within the skull, as in the case of tumors of the pituitary and pineal glands. In this connection it is considered that these vasomotor disturbances will not result in headache unless associated with retention of water. This results from faulty action of the endocrine system usually in connection with extreme dietary indiscretions. Increased retention of sodium favors the retention of water, and this in turn causes increased volume, and hence pressure, within the skull, causing headache. Treatment consists of displacement of the sodium by restricting the intake and substituting ammonium chloride, reducing the vasomotor irritability by atropine and phenobarbital, and by suitable endocrine therapy, principally thyroid or pituitary extracts or estrogenic compounds. Regulation of the diet and avoidance of emotional disturbances, overfatigue and nervous strain should be a habit constantly observed.

Migraine is as yet not well understood. It may have a single cause or a variety of causes, and is more of a symptom complex than a disease. In order to diagnose migraine in a given case it must present at least three of its four cardinal symptoms, which are (1) recurrent hemicranial pain, (2) visual symptoms, (3) gastrointestinal symptoms and (4) a hereditary background of migraine. Theories of the causes of migraine may be placed under three heads, (1) allergy, (2) endocrine disturbances, especially gonadotropic hyperactivity, and (3) psychoneurosis. Of course the tendency to migraine is believed to be hereditary. Much investigation of this distressing condition has been made, but no more definite conclusions have been reached. Treatment must be directed at the underlying cause, but relief is practically always obtained by injections of ergotamine tartrate and seldom by any other remedy.

#### SUMMARY

Headache may, therefore, be summarized as being an indication of too much within the skull. In the congestive type there is too much in or around the blood vessels. In the noncongestive or anemic type there is too much within the ventricles. The problem is to find out what, in each case, is causing the "too much." Intelligent treatment will be directed at the cause.

## SULFANILAMIDE SENSITIZATION

### REPORT OF RENAL AND HEPATIC DAMAGE IN A FATAL CASE

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and  
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MIAMI BEACH

The case described presents a diagnostic problem in the etiology of acute hepatitis, associated with a nephrotic syndrome. The onset was sudden, and the predominant symptoms were chills and fever, general malaise, nausea, vomiting, jaundice, myalgia, purpura, albuminuria, edema, hepatomegaly and leukocytosis. The symptoms were classical for leptospirosis icterohaemorrhagica (Weil's disease, spirochetal jaundice). The picture was complicated by the fact that the patient was originally treated for a gonorrhreal infection, receiving from 500 to 700 grains of sulfanilamide in two or three intermittent courses. There was also a history of catarrhal jaundice during childhood, which may have been a factor in the subsequent development of acute hepatitis from the drug because of this early damage to the liver.

Bannick, Brown and Foster<sup>1</sup> reported 2 deaths from hepatitis following the use of sulfanilamide, which may have accentuated preexisting hepatic damage. Jaundice as a complication of sulfanilamide therapy was reported by Hageman and Blake.<sup>2</sup> Saphirstein,<sup>3</sup> Long<sup>4</sup> and Garvin<sup>5</sup> reported 5 cases with 1 death. A further review and a bibliography are contained in the articles written by Green and Hotz<sup>6</sup> and recently by Watson and Spink.<sup>7</sup>

The question of sensitization of the liver following intermittent treatment with sulfanilamide was considered in our case. Cline<sup>8</sup> reported a case of acute yellow atrophy of the liver with death in a patient who was given sulfanilamide for gonorrhreal urethritis followed by rest and then another course. Fitzgibbon and Silver<sup>9</sup> reported a case of gonorrhea in which 500 grains of sulfanilamide was given within a period of from ten to fourteen days. Six weeks later the patient took 15 grains of this drug, and an urticarial rash with severe jaundice developed. Their belief was that the patient was sensitized with the initial large dose.

In the case presented there was a period of from three to five days during which no sulfanilamide was taken. This may demonstrate the so-

called period of "silent incubation" referred to by Ottenberg.<sup>10</sup> Jaundice appears from two days to several weeks following the last administration of sulfanilamide. This interval is likened to the preicteric period noted by Bergstrand<sup>10</sup> in cases of an infectious type of acute yellow atrophy. Ten years ago in Sweden there was an epidemic of catarrhal jaundice followed by an epidemic of acute yellow atrophy. This author noticed a preicteric period lasting from ten to thirty days wherein the liver gradually became enlarged, and only when damage reached a certain degree did icterus occur.

### REPORT OF CASE

F.B., a woman aged 35, separated from her husband, entered the hospital on Dec. 7, 1939, complaining of nausea, vomiting, severe jaundice and pain in the muscles of both legs and the left elbow. She had been in good health until November 18 when she noticed a vaginal discharge, the cause of which was diagnosed as gonorrhreal infection. She also had "swollen lymph glands in the region of her neck and an elevated temperature." She was hospitalized and was given "two white tablets four times a day" for ten days. Both the temperature and the discharge subsided. Upon the recommendation of her physician, she came to Miami to recuperate. Shortly thereafter an "abscess on her vagina" developed, and she consulted a gynecologist who hospitalized her in Miami and gave her the benefit of surgery. While in the hospital she was again given sulfanilamide and she continued taking the drug for several days following her discharge. She was convalescing satisfactorily until two or three days before entering St. Francis Hospital, when she noticed a "yellow coloring in the whites of her eyes" and was nauseated.

On admission, the temperature was 98, the pulse rate was 70, respirations were 20, and the blood pressure was 98 systolic and 40 diastolic. The skin and conjunctivas were greatly jaundiced. The abdomen was soft, the border of the liver was at the costal margin, and some tenderness was present in this region. The spleen and kidneys were not palpable. The neurologic examination gave negative results. The patient related that she had had catarrhal jaundice at the age of ten, a fracture of the left forearm at twenty-five years of age and a miscarriage at thirty years of age.

Urinalysis revealed a trace of albumin, numerous to occasional pus cells and evidence of bile, but no evidence of sugar or urobilinogen. The specific gravity was 1.005.

The report of the examination of the blood was red cells 3,600,000, white cells 16,050, polymorphonuclears 90, lymphocytes 9, stab cells 14 and segmented forms 76. The hemoglobin estimation was 69 per cent. The Kahn test gave negative results.

On December 8 the temperature rose to 103 F. and was of a septic type throughout the course. Blood cultures were obtained, but remained sterile during the entire period of the illness. On December 12 the edema became more pronounced. Ptosis of the left eyelid developed. Both pupils were constricted and equal. The extraocular movements were normal in both eyes. There was no evidence of involvement of other cranial nerves. Only the branch of the third nerve which innervates the levator palpebrae superioris was affected. The blood pressure was 100 systolic and 60 diastolic. The patient was mentally alert and was complaining of pain in the muscles of the legs and the left elbow. She was given 500 cc. of citrated blood because of a decrease in red blood cells and because of the great increase in the edema. Following the transfusion the total proteins were 7.31 Gm., and the edematous condition was improved.

The jaundice increased. On December 15 the icterus index was 98 and it remained at this level throughout the illness. The red blood cell count was almost 5,000,000 with a cell volume of 38 per cent, but the white blood cell count increased from 19,000 to 50,000 with a differential count showing 90 to 95 per cent polymorphonuclears, which were vacuolated and remained so to the end. The total proteins decreased to 5.2 Gm. The nonprotein nitrogen was 41 mg. The blood chlorides were 400 mg., and the blood cholesterol was 100 mg. A bromsulfalein liver function test showed 100 per cent retention of the dye at five minutes and 45 per cent retention at thirty-five minutes. The margin of the liver could now be palpated three fingerbreadths below the costal margin.

The treatment consisted in watching the blood picture and blood chemistry, and giving transfusions to maintain the blood level, cell volume and protein level. Saline solution and a 50 per cent solution of hypertonic glucose were administered intravenously as indicated by repeated chloride and cell volume determinations.

A dark field examination of the blood and urine was made on December 16 and 17, nine and ten days after the onset of the illness, by Drs. Philipp R. Rezek and Theodore M. Berman. The report was negative for *Leptospira icterohaemorrhagiae*. Two guinea pigs were inoculated intraperitoneally with the patient's blood, but neither fever nor jaundice characteristic of leptospirosis icterohaemorrhagica developed in these animals. Blood was sent to the National Institute of Health, Washington, D. C., and also to Johns Hopkins University for agglutination studies, which gave negative results for the type I L. icterohaemorrhagiae.

The ptosis of the left eyelid gradually improved and was almost gone on December 21. In spite of repeated administration of fluids and transfusions, the patient became more toxic and edematous. The nonprotein nitrogen steadily increased to 150 milligrams per hundred cubic centimeters. She died in coma on December 27, twenty days after admission. Anuria developed five days before death.

**Autopsy**—The autopsy was performed by Drs. Rezek and F. H. Dieterich, approximately four hours after death. In addition to the jaundice, purpuric spots and generalized edema, the significant pathologic changes were in the brain, heart, spleen, kidneys, bladder and liver.

There was edema of the brain. Microscopically, there were areas of focal necrosis.

The pericardial cavity was enlarged and contained a large amount of hemorrhagic fluid. The heart was completely covered with a fibrinous exudate. Microscopically, there were areas of focal necrosis in the myocardium surrounded by small round and reticuloendothelial cells. The pericardial layer of inflammatory tissue showed numerous fibroblasts and round cell infiltration.

The spleen weighed 1,000 Gm. and was soft. The capsule was tense, and the cut surface was purplish red with small dark areas indicating hemorrhage. Microscopically, there was active hyperplasia surrounding the malpighian capsules.

The kidneys each weighed 400 Gm. There were petechial hemorrhages in the renal parenchyma and the lining of the pelvis. The cut surfaces bulged. Microscopically, the tubular epithelium showed albuminoid degeneration with albumin in the lumen. There was cellular increase in the glomerular tuft, and albuminoid deposit was observed in the lumen of Bowman's capsule.

The urinary bladder was distended. The mucous membrane was injected and had areas of purulent exudate covering small ulcers. Microscopically, there was focal necrosis with round cell infiltration.

The liver weighed 4,000 Gm. The edges were blunt and rounded. It was dark yellowish, green-brown, and its structure was well preserved. The centers of the lobules were brown-red, and the periphery was yellow-brown. Microscopically, the liver showed generalized widespread necrosis. There was no special predilection

for the central vein as is seen in chemical poisoning such as that caused by chloroform, nor peripheral necrosis, as seen in eclampsia or midzone necrosis, with cellular reaction as seen in bacterial necrosis. The polymorphonuclear reaction seen in bacterial reaction was lacking.

The pathologist's opinion follows:

There were two factors at work providing the ultimate demise of the patient, namely, sepsis and hepatic insufficiency resulting from a central necrosis of the liver lobules. I do not believe that a bacterial toxemia would produce this type or extent of necrosis.

Sections of the liver, kidneys and spleen in saline solution were sent for sulfanilamide determination to Dr. Perrin H. Long of Johns Hopkins, to whom we are deeply indebted. The tests gave negative results for sulfanilamide in the saline solution, liver and kidneys, but there was a possibility of a faint trace of acetylated sulfanilamide in the spleen because of a very faint pink reaction which may have represented a blank.

Two guinea pigs were injected intraperitoneally with a saline emulsion of the liver, but they died within twelve hours from peritonitis due to *Bacillus coli*.

## DISCUSSION

Because of the typical symptoms of Weil's disease and because this disease should be considered in every case of unexplained jaundice, an attempt was made to confirm the clinical picture by

1. Dark field examination of the blood and urine.
2. Injection of blood intraperitoneally into guinea pigs.
3. Demonstration of specific antibodies in the blood by agglutination.

**Dark Field Examination of the Blood and Urine**—Gaines and Johnson,<sup>11</sup> reported 7 cases in which they found that examination of the blood was the most satisfactory method of diagnosis and not time-consuming. Leptospires were present in the blood of all their patients, but they were unsuccessful in demonstrating them in the urine. These spirochetes are found in the blood during the first week and in the urine thereafter (Giemsa stain').

**Guinea Pig Intraperitoneal Injection of Blood**—Six days after the injection, the animal should become toxic, fever and jaundice should develop, and death should ensue on about the tenth day. At necropsy, organisms are found in the blood, urine, liver and kidneys. They were present in 4 of the 7 cases reported by Gaines and Johnson, two each for blood and urine injections. Laboratory workers have urged repeated subinoculation of material from successive animals, which may finally lead to the isolation of the organism. They advise the use of guinea pigs weighing less than 175 Gm. or even nursing animals.

**Demonstration of Specific Antibodies in the Blood by Agglutination**—The antibody titer rises rapidly in the third week of the disease and

reaches a level of 1/40,000 by the end of the fifth week. It is most remarkable that the reaction has been obtained from twelve to twenty-two years after infection. It has been stressed that in performing the serologic test it is well to use both *L. icterohaemorrhagiae* and *Leptospira canicola* as antigens. In some cases it is necessary to test various strains of *L. icterohaemorrhagiae* for exact identification of the immune bodies in the patient's serum.<sup>12</sup> Clinically and etiologically there are four general types of human leptospirosis:<sup>12</sup> (1) leptospirosis icterohaemorrhagica, characterized by abrupt onset with fever, vomiting, great prostration, severe myalgia and jaundice; (2) the type caused by *L. canicola*, which is usually anti-icteric, but meningeal symptoms are prominent; (3) swamp fever of central Europe and (4) seven day fever of Japan.

It is interesting to note that in the 7 cases reported by Gaines and Johnson<sup>11</sup> the source and mode of infection were not determined and, except for the case reported by Wadsworth<sup>12</sup> in 1922, in which a laboratory worker was infected, and the case of Mortimer,<sup>13</sup> in which a child was infected by a dog, in all of the 11 cases reported in North America the source was likewise not determined. In the case considered in this paper there was no history which would lead one to suspect contact with *Leptospira*, and all the laboratory procedures gave negative results.

Inada<sup>12</sup> divided the disease into three stages:

1. Febrile stage, which is similar to any infection and lasts from four to seven days.
2. Icteric stage, which lasts one week. Death usually occurs during this stage from hepatic, renal or cardiac damage.
3. Convalescent stage, in which the jaundice subsides and anemia and emaciation are present in considerable degree. Without icterus the prognosis is favorable.

The distribution of *L. icterohaemorrhagiae* is worldwide. Leptospirosis icterohaemorrhagica is conveyed by rats and is prevalent among miners, sewer workers, bargemen, garbage workers and fish cutters. Dogs have been known to infect humans as in the case reported by Mortimer<sup>13</sup> of a child who was bitten by a pet dog which was proved to have had *L. icterohaemorrhagiae*. Our patient's history did not seem important regarding this condition. It is interesting to note that a fish cutter in New York contracted leptospirosis while at work and was given compensation.<sup>14</sup>

Leptospirosis could not be confirmed by the laboratory procedures in our case; therefore, on the basis of the history of sulfanilamide therapy and the pathologist's report it was concluded that the toxic hepatitis and nephrosis were caused by the sulfanilamide. The cases reported of jaundice due to sulfanilamide have always been associated with agranulocytosis and anemia, but in this case anemia and leukocytosis in great degree were present.

In discussing the toxic effects of sulfanilamide Ottenberg<sup>10</sup> described two types of anemia and jaundice. The first type is a hemolytic anemia and comes on rapidly or slowly without hemoglobinuria and without jaundice. The second type is an acute hemolytic anemia, intense hemoglobinuria and mild jaundice. The hemoglobinuria may lead to suppression of urine.

The first type of jaundice is associated with simple benign anemia or the acute hemolytic anemia of the second type mentioned. There is no evidence of toxic hepatitis. The second type of jaundice shows all the manifestations of toxic hepatitis and may be accompanied by hemolysis.

Ottenberg<sup>10</sup> commented on the difficulty of making a prognosis in the early stages of hepatic degeneration of catarrhal jaundice. Without regard to symptoms, often the mildest forms go on to acute yellow atrophy. When, however, there are an unusually low blood cholesterol and cholesterol ester with a corresponding rise in blood bilirubin after only one week of jaundice, the condition is regarded as a severe parenchymal injury and is called the cholesterol collapse of Thannhauser. This fact was demonstrated in the case reviewed.

The hemorrhagic diathesis in this case probably points to a decrease in blood fibrinogen, indicates parenchymal disease of the liver and also suggests that the liver is the organ for production of fibrinogen.<sup>15</sup>

Recently Watson and Spink<sup>7</sup> made a study of the effect of various doses of sulfanilamide and sulfapyridine on hepatic function and hemoglobin metabolism in 110 cases treated with sulfapyridine. There were 16 cases of jaundice in this group. Furthermore, in all of these cases the patient received sulfanilamide. Their conclusion was that sulfapyridine is less frequently a cause of jaundice in spite of the smaller number of cases studied. No jaundice was observed, however, in an adult receiving less than 3 Gm. of sulfanilamide daily, but when doses of 4 to 8 Gm.

were given daily, disturbances of hepatic function occurred in most cases, depending on individual susceptibility to the drug and the toxicity of the underlying diseases with respect to the liver.

#### SUMMARY

In a case of severe jaundice with a white blood cell count ranging from 20,000 to 50,000 *L. icterohaemorrhagiae* must be borne in mind. A simple dark field examination of the blood during the first week of illness will reveal the leptospirosas, which are not difficult to demonstrate.

The case presented demonstrates the fact that oftentimes the liver may be sensitized to a drug such as sulfanilamide, whereupon subsequent chemotherapy may result in extensive toxic hepatitis and nephroses. Too much stress cannot be placed on obtaining a thorough history regarding diseases of the liver previously experienced. The fact that the patient in our case had simple catarrhal jaundice as a child no doubt played an important part in the subsequent toxic hepatitis and nephrosis due to sulfanilamide.

The alcoholic history was not significant insofar as we know. Since we were unable to confirm the clinical syndrome of Weil's disease by laboratory procedures, we concluded that this was another case of extensive necrosis of the liver with associated nephrosis, transient neuritis, purpura and death caused by sulfanilamide. In

all questionable cases it is incumbent upon the clinician to have routine conventional hepatic and renal function tests performed before instituting chemotherapy.

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## SOUTHERN MEDICAL ASSOCIATION

The thirty-seventh annual meeting of the Southern Medical Association will be held in Cincinnati on November 16 to 18. It convenes upon the invitation of the Campbell-Kenton County Medical Society of Kentucky.

The program for this meeting will be different from those of previous years, owing to wartime conditions. The twenty-one sections of the Association will not meet independently, but each section will furnish a certain number of papers for the general sessions.

There will be two general sessions each day, one representing the various surgical specialties, and the other the medical specialties. The essayists on Wednesday and Thursday will be about equally divided between physicians in the armed forces and in civilian practice. There will be time for questions and answers following each paper. Thursday will be Kentucky and Ohio Day, and the program will be filled by physicians from both sides of the river.

On Tuesday evening, in a general public session, the address of the president, Dr. Harvey F. Garrison, Jackson, Mississippi, will be heard. There will also be addresses by Dr. James E. Paullin, Atlanta, president of the American Medical Association, and Dr. Norman T. Kirk, Surgeon General, Medical Corps, U. S. Army, Washington.

There will be no formal entertainment this year, no president's reception, no golf or trap shooting tournaments. There will probably be a general alumni dinner on Wednesday evening and fraternity luncheons on Thursday.

The Netherland Plaza Hotel will be general headquarters. Here will be held the registration, general sessions, the scientific, hobby and technical exhibits, all official activities of the Southern Medical Association. The Gibson Hotel is headquarters and meeting place for organizations meeting conjointly. The Sinton Hotel is headquarters and meeting place for the Woman's Auxiliary.



## FLORIDA'S PROGRESS IN VENEREAL DISEASE CONTROL ACTIVITIES

That a progressive program for venereal disease control is under way in Florida is reflected in the following report:

In the state, during 1942, 30,174 cases of syphilis and 10,174 of gonorrhea were reported to the State Board of Health. More cases of venereal disease were reported each week, on the average, in 1942, than of poliomyelitis during the last twenty years, and there were twice as many cases of venereal disease as of tuberculosis in the same period. The monthly average of patients under treatment in clinics for venereal disease in 1941 was 12,500, which increased to 20,131 in 1942. Florida has 153 venereal disease clinics operating within reach of 95 per cent of the population unable to pay a private physician. Forty-seven of these clinics were organized during the last six months of 1942.



## MEDICAL AND PUBLIC OPINION MOUNTING AGAINST WAGNER-MURRAY-DINGELL MEASURE

During the past two months there has been a mustering of medical and public opinion against the Wagner-Murray-Dingell bill which indicates an awareness by the medical profession and the public of the tremendous stake that they have in this legislation, *The Journal of the American Medical Association* for September 4 points out. *The Journal* calls for unity in the medical profession in the attack on the technic for rendering medical service proposed by this legislation. *The Journal* says:

Hearings on the Wagner-Murray-Dingell bill, which was fully analyzed by the Bureau of Legal Medicine and Legislation of the American Medical Association and commented on editorially in *The Journal*, June 26, will no doubt be held in the near future, probably after Congress has completed the new tax bill. According to the *United States News*, advocates of the expansion program for social security assert that it has caught the popular fancy, that pressure for its adoption is increasing daily, that the plan is a big step toward one

of the Four Freedoms of the Atlantic Charter—Freedom from Want—and that Congress would face a storm of public criticism if it failed to approve the main provisions of the plan. On the other hand, opponents assert that the program would constitute a capital levy of ruinous magnitude on United States business, that even with the 12 per cent payroll tax the plan would be underfinanced, and that, should Congress enact such a bill, a dominant bureaucracy would be created which would end free enterprise in the United States and alter the whole way of American life.

The editorial published in *The Journal* on June 26 emphasized that this bill is an evolution of the National Health Conference of 1937. It pointed out further that the measure was prepared without consultation with the medical profession, that it would make the Surgeon General of the United States Public Health Service a virtual "gauleiter" of American medicine and that it would be, in fact, the acme of bureaucratic control of medical service. In the two months that have passed there has been a mustering of medical and public opinion against this measure, indicating awareness by the medical profession and the public of the tremendous stake that they have in this legislation. The editor of the McKeesport (Pa.) *Daily News* states the case succinctly:

It would place the doctors under political control and provide for the mass of the people physicians who are politically amenable rather than those with superior abilities and skills. And would deaden one of the most highly regarded professions the world has ever known. Success of bill 1161 and the destruction of the freedom of American medicine would be the come-on for other broader, more revolutionary schemes to circumscribe the American people.

The periodical *America* says, in a statement by one of its editors:

Now, will public regimentation of health servants operate to preserve the profession and thus ultimately help to preserve the body politic? It seems that such action—as, for example, that contemplated in Senate Bill 1161—would create a new class of political doctors. And in America political classes are commonly subject to the influence of political practice, in seeking emoluments and avoiding burdens, unless we take the rare case of the unusually elevated individual. The system as it works does not raise personal ideals. But doctors without high personal ideals are a menace, both to the patient and to the public.

An editorial in the Middletown (Ohio) *News Signal* says:

The Wagner bill will be considerably modified, but some of its worst features may become law unless it is seen in its true light. It is part of a program, now well advanced, to enslave the individual to the state. In this process he gradually loses his adult self reliance, lapses toward infancy and then degenerates into a willing slave of government.

The Charleston (S. C.) *News-Courier*, in a sarcastic editorial contribution, emphasizes the political aspects of this measure. It suggests that the medical administrators under the Wagner-Murray-Dingell bill be elected by popular ballot. The medical administrator would have the right to appoint the doctors and assign the cases. He could expect the support of the doctors that he appointed to help him get reelected, and the doctors would use their automobiles and C cards to help haul voters to the polls. They could also contribute to a fund to buy radio time for campaign speakers. Any doctor who worked against the medical director's reelection might find it difficult afterward to practice. Appointments in the medical colleges would, of course, be handled like other political patronages so that deserving party members could have their sons trained free of charge. Incidentally, it is pointed out, a lot of useful confidential information could be picked up by the doctors on their rounds that would help the party to stay in office.

And the Jackson (Tenn.) *Sun* comments metaphorically:

We are indeed a sick nation if we are willing to swallow such a pill. After swallowing it we would find that, instead of taking a progressive stimulant, we had taken a political opiate intended to dull our senses. . . .

The editor of the Buffalo *News* suggests that the proposed measure provides for a setup "closely approaching that in the totalitarian nations." He urges, further-

more, that the people, if they have put upon them the full measure of social security proposed by the New York senator, "soon would be in a condition to yield themselves up as wards of the state."

At its meeting held in Chicago on August 26, the American Bar Association gave its approval to a resolution opposing any legislation now before Congress which "seeks to establish federal control of the medical profession and the regimentation of doctors and hospitals."

The periodical *Medical Care*, edited by Mr. Michael Davis, suggests that the Wagner-Murray-Dingell bill was introduced on the demand of organized labor for the expansion of social security and that the timing may be accounted for by the probability that realists who are pushing this bill are more hopeful of dramatizing an issue for 1944 than of congressional action this year. The editorial indicates, incidentally, that the bill goes beyond the plans put forth by the President and the Social Security Board.

In his editorial Mr. Michael Davis suggests that American physicians can now be divided into three groups: those who support the policies of the American Medical Association, those who differ with them but who keep silent and those who differ and say so publicly. Mr. Davis takes great encouragement from the statement recently released by Drs. John Peters, Channing Frothingham and others which apparently indicates to him a division in the medical profession and a gathering of strength against the policies of the American Medical Association.

Already an announcement has been made in the press that Senators Wagner and Murray propose to have early hearings on this measure. Certainly the Board of Trustees and the newly established Council on Medical Service and Public Relations will give early consideration to the manner in which the American Medical Association is to be efficiently represented in the proposed hearings.

Regardless of any other considerations on which there might be a difference of opinion among the vast majority of physicians of the United States, unity is demanded in the attack on the technic for rendering medical service proposed by the Wagner-Murray-Dingell bill. Senator Wagner in his public statement said, "I do not claim this bill is in any sense a perfect instrument; it is offered simply as a basis for legislative study and consideration." Let us take the Senator at his word and prove to him and his colleagues, by a complete and forceful presentation of the points of view of American medicine, how far from perfect is the measure that he has proposed.



#### VISCOSE TUBING FOR TRANSFUSIONS

Because the cleansing of rubber tubing to be used for intravenous administration of blood or blood protein is difficult and incomplete cleansing is believed to be a major cause of pyrogenic or fever producing reactions, a heavy walled Viscose tubing (made of a synthetic substance) is used by Henry Naftulin, A. M. Wolf, M. D., and S. O. Levinson, M. D., Chicago, they report in *The Journal of the American Medical Association* for October 9.

They say that "in a total of 1,137 blood transfusions given through Viscose tubing the incidence of pyrogenic reactions was 0.64 per cent. This is a material decrease from the reaction rate encountered with rubber tubing."

## WAR SURGERY IN A MILITARY HOSPITAL IN THE MIDDLE EAST

The salient features of war surgery in a British military hospital in the Middle East during part of the North African campaign are discussed by *The Journal of the American Medical Association* for October 2 as follows:

During the last nine months of 1942, 3,279 battle casualties were admitted to one military hospital on the lines of communication in the Middle East. Because of the enemy's rapid advance to El Alamein the arrival of wounded was so rapid that the hospital had to act as a casualty clearing station rather than as a base hospital. The mortality rate for the 300 casualties from Tobruk was 3 per cent and for the 500 casualties from the second battle of El Alamein it was 10 per cent. The mortality rate for 2,679 casualties from the first battle of El Alamein when the hospital acted as a casualty clearing station, was only 1.3 per cent. The high mortality rate for the casualties from Tobruk and from the second battle of El Alamein is due to the fact that seriously ill patients were sent to the hospital.

The figure 1.3 per cent is approximately accurate for most casualty clearing stations. In analyzing the results, Lieut. Col. R. K. Debenham (in the *British Medical Journal*) emphasizes that all of the wounds dealt with were a result of fighting in dry sandy desert, that the amount of clothing worn was very small so that only rarely was clothing found in a wound, and that sulfanilamide was used prophylactically. As a routine 10 Gm. was dusted into the wound and another 10 Gm. after operation; 5 tablets (2.5 Gm.) were given by mouth at 6 a. m. and 6 p. m. daily for four days. The good results obtained in abdominal cases, particularly in those with bowel perforation, were due to early operation. Of the 11 patients with bowel perforation, the 9 who recovered were operated on in forward areas and were kept there from five to sixteen days; the cardinal points seem to be early operation, late evacuation, intravenous saline drip, continuous gastric suction and sulfadiazine. This is difficult with mobile warfare but was possible when the line of battle was static.

The worst cases of burns came from fighting in tanks. Because facilities for preliminary cleansing were not obtainable, tannin was discarded in favor of cleansing and powdering the area with sulfanilamide and dressing with petrolatum gauze. Patients traveled best with plenty of padding and in the cases of wounded limbs a light, well padded plaster of paris cast was definitely beneficial. In the early stages intravenous plasma or serum was considered essential. Blood transfusions were used for secondary anemia a week or ten days later. Patients with severe burns traveled badly, even up to two weeks after burning. After a long journey they arrived toxic and ill. It is easy to put too much sulfanilamide powder on the burns, especially in severe cases, as sulfanilamide is readily absorbed from burned areas and gives rise to profound toxemia. Blood and plasma or serum transfusions were used for shock, for burns and during convalescence when the hemoglobin fell below 60 per cent.

Gas gangrene has been rare and gas infection uncommon. No case of tetanus has been seen. . . .

The salient features of war surgery in the Middle East are based on the principles which have been in the process of evolution since the beginning of the war. They are summarized as follows: organized resuscitation and the use of local and general sulfanilamide; thorough immobilization; conservative surgery and wound trimming instead of wound excision; avoidance of tension around wounds and provision of a good blood supply in damaged limbs, and the necessity to adapt and improvise articles to fulfil functions for which they were not intended.



## AMAZING REDUCTION IN MENINGITIS DEATH RATE

In a series of 1,518 cases of meningococcic meningitis and septicemia in the Army's Fourth Service Command during the winter and spring of 1942-1943, an early mortality rate of 8.8 per cent in 317 cases was lowered during February and March to 2.1 per cent in 761 cases, Colonel Henry M. Thomas Jr. reports in *The Journal of the American Medical Association* for October 2. Colonel Thomas says:

This amazing reduction in mortality from 39 per cent in the last war to less than 3.5 per cent in the present war is due entirely to chemotherapy. It is true that the most desperately ill patients may require additional therapeutic measures but for over 95 per cent of all patients chemotherapy properly administered is the only specified form of treatment necessary.

Of the various sulfonamide compounds sulfadiazine has up to the present proved to be the most satisfactory in the treatment of meningococcic infections. It is more efficacious than sulfanilamide, and with one important exception it is much less toxic than sulfapyridine and sulfathiazole. . . . If all patients could be given a diagnosis and treated at the onset of the first symptom, it is my firm belief that the mortality would be reduced to zero. However, the disease is often masked by the absence of pathognomonic symptoms and by the simultaneous occurrence of many infections of the upper respiratory tract presenting similar symptoms. This leads inevitably to loss of time in treatment in a few cases. In other cases the infection is so virulent that the patient dies before treatment can be given or before treatment has an opportunity to stem the tide of infection. . . .

The feasibility and effectiveness of large scale prophylactic use of sulfadiazine in the reduction of carriers and the prevention of cases are being demonstrated. It has been possible then to compensate by improved methods of treatment and prophylaxis for the rapid training program which necessitated fatigue, exposure and crowding of unseasoned troops. It seems safe to prophesy that in succeeding years the case rate can be greatly reduced by prompt prophylactic treatment at suitable points, particularly among unseasoned troops. It seems equally safe to prophesy that the mortality from the cases that do develop will be held to low levels, although the occasional cases of fulminating disease probably will continue to produce a small number of deaths.



## MEMBERS IN ARMED SERVICES

Names and home addresses of members in the armed services, by county societies.  
Please report omissions or corrections to Box 1018, Jacksonville 1.

### ALACHUA

Andrews, Edwin H.	Gainesville
Cobb, Alva T.	"
Collins, Grover C.	"
Dell, J. Maxey, Jr.	"
Jennings, Lloyd H.	Starke

### BAY

Adams, Daniel M.	Panama City
Parker, Martle F.	"
Roberts, William C.	"

### BREVARD

Cooke, Frank N.	Cocoa
Hay, I. M.	Melbourne

### BROWARD

Blount, Robert E.	Ft. Lauderdale
Camp, Milton N.	"
Carson, Russell B.	"
<sup>2</sup> Cohn, Jess V.	Hollywood
Farringer, Robert H.	"
Lovejoy, M. Austin	Ft. Lauderdale
Lumpkin, Lloyd U.	"
Peavy, Henry J.	"
Pierce, Francis D.	"
Shell, Paul G.	"
Snyder, F. Leslie	Hollywood
Sory, Curtis H.	Ft. Lauderdale

### COLUMBIA

Busey, John F., Jr.	Lake City
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### DADE

Adler, Lawrence	Miami
Agos, I. H.	Miami Beach
Alexander, Julius	Miami
Alexander, Lassar	"
Allen, Ralph F.	"
Arango, Roger J.	"
Auslander, Harold P.	Miami Beach
Baker, Juel M.	Miami
Barge, William J.	"
Bernstein, William H.	Miami Beach
Bertram, Albert J.	Miami
Boughton, Herman	Miami Beach
Burbacher, Charles R.	Coral Gables
Burch, John E.	Miami
Capland, Lewis	Miami Beach
Carroll, Bruce D.	Miami
Christian, William A.	Miami Beach
Clark, Irving T.	Miami
Cleveland, Jack Q.	Coral Gables
Cogan, James R.	Miami Beach
Coleman, Benjamin	"
Coplan, Milton M.	Miami
Cullipher, Edward W.	"
Dees, John	"
<sup>2</sup> DeVore, Louise	"
Dierich, Frederick H.	"
Dix, John W.	Coral Gables
Dowlen, L. Washington	Miami
Dowlen, Otto S.	Miami Beach
Eichert, Herbert	Miami
Elam, James O.	"
Exley, David W.	Miami Beach
Falk, Jack J.	"
Fishbein, I. Leo	"
Fitzpatrick, Emmett T.	"
Forastiere, Roger J.	Miami
Fox, Edward F.	"

Frehling, Stanley	Miami
Frobisher, H. B.	Coral Gables
Garrard, Hollis F.	Miami Beach
Goodman, Bernard	"
Gross, Alfred	"
<sup>2</sup> Hanna, Fuad	Miami
Hardie, Dan, Jr.	"
Harris, Robert M.	"
Hewlett, Frank W.	Coral Gables
Hinton, Andrew H.	Miami
Howell, R. Spencer	"
Hutson, Thomas W.	"
Jack, Ralph W.	"
Jenkins, Leslie M.	"
Kauders, Ferdinand H.	"
Kells, Paul	"
Kline, Bernard	Miami Beach
Kuckku, Morris E.	Miami
Kupper, William H.	"
Lamar, Carlos P.	"
Lawther, Harry C.	"
LeDrew, Frederick	"
Leonard, George N.	Miami Beach
Levin, Alfred G.	Miami
'Lister, George	Miami Beach
Litterer, A. Buist	Miami
McClamroch, James M.	"
McElheny, Franklin	"
McKenzie, E. Norton	"
McKenzie, Jack A.	"
McLemore, Carl S.	Miami Beach
McLeod, Norman W., Jr.	Miami
Marion, Dominic A.	"
Martin, Marion C.	"
Maxwell, Eugene B.	Miami Beach
Messner, Paul O.	Miami Springs
Milton, John D.	Miami
Mitchell, George A.	"
Mosley, R. Sam	"
<sup>2</sup> Mouradian, Albert H.	"
Nathan, David A.	Miami Beach
Nuzum, Russell K.	Miami
O'Donnell, William G.	"
Oliver, Robert M.	"
Otto, Thomas O.	Miami Beach
Owens, W. Duncan	"
Payton, Frazier J.	"
'Pearce, N. O.	"
Pearson, Julius R.	"
Pearson, R. Judson, Jr.	"
Pepper, Max	Miami
Phillips, Kenneth	"
Pollock, Benjamin G.	Miami Beach
Preston, Edwin P.	"
Putman, James H.	Miami
Quillian, Warren W.	Coral Gables
Rand, Harold	Miami
Rash, Jack O. W.	"
Reckson, Murray M.	Miami Beach
Reese, Homer A.	Miami
Richardson, John R.	Miami Beach
Robbins, Alexander	"
Robbins, Bernard	"
Roberts, Thomas L.	Coral Gables
Rogers, Hunter B.	Miami
'Roth, Edward	Miami Beach
Salley, S. Marion	Miami
Sandberg, T. D.	Coral Gables
Sappenfield, Ralph S.	Miami
Saslaw, Milton S.	"
Scarborough, C. A.	"

Schwarz, M. Jandon	Miami Beach
Selevan, Sol	"
Silverman, Harry Z.	"
Sisler, Bruce H.	Miami
Skilling, Francis C.	"
Spicer, Robert T.	"
Stannus, Donald G.	Miami Beach
Sternberg, J. Charles	Miami
Stewart, Franz H.	"
Stewart, Joseph S.	"
Thomas, Efton J.	Miami Beach
Torrado, Rene A.	"
Travers, M. Paul	"
Turk, John P.	Miami
Vinson, Willie J.	"
Voris, Frank B.	Miami Beach
'Walker, H. A.	"
Wallace, Albert W.	"
<sup>2</sup> Walsh, Gerald J.	Miami
Walterman, David	Miami Beach
Weiland, Arthur H.	Coral Gables
Werblow, S. Charles	Miami
Whelchel, Lynn W.	"
Whitmer, Kenneth S.	"
*Wigdor, Meyer	Miami Beach
Woods, Frank M.	Miami
Youmans, Corren P.	"
Zimmerman, Paul A.	Coral Gables
Zivitz, Nelson	Miami Beach

### DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

McSwain, Gordon H.	Arcadia
Martin, Leldon W.	Sebring
Simmons, S. J.	Belle Glade

### DUVAL

Adams, Thomas S.	Jacksonville
Baker, Archie J.	"
Baldwin, Donald M.	"
Ball, William H.	"
Bedell, Sullivan G.	"
Borland, James L.	"
Bowen, Frederick H.	"
Boyd, Charles W.	"
Canipelli, Edward	"
Carithers, Hugh A.	"
Croft, George W.	"
Ferrara, John D.	"
Funkenstein, Dan H.	"
Galin, Jack	"
Gorman, John M.	"
Graves, A. Judson	"
Hanson, Karl	"
Haverfield, W. Tracy	"
Hurt, Floyd K.	"
Kemp, Simon L.	"
Kendrick, M. Hayne	"
King, F. Gordon	"
King, Raymond H.	"
Kirk, William W.	"
Leitner, Elmer E.	"
Lipscomb, T. H.	"
Lombardo, Samuel S.	"
Lovejoy, John F.	"
McCall, E. Frank	"
McCullagh, William H.	"
Malone, Bert H.	"
Mangels, Martin, Jr.	"
Manning, William S.	"

MEMBERS IN ARMED SERVICES—Continued

Manson, A. Mackenzie Jacksonville  
 Mathers, Daniel H..... " "  
 Mendoza, Carl C..... " "  
 Milam, Ernest B..... " "  
 Nelson, Thomas F..... Tampa  
 Oberdorfer, Aaron Z..... Jacksonville  
 O'Dell, John C..... " "  
 Oetjen, G. F..... " "  
 Parks, Lorenzo L..... " "  
 Patterson, James N..... " "  
 Pickett, W. H. Kansas City, Kans.  
 Porter, Harry W..... Jacksonville  
 Richards, Ferdinand..... " "  
 Rose, Joseph..... " "  
 Safer, Jacob V..... " "  
 Simmons, Eugene D..... " "  
 Slaughter, Frank G..... " "  
 Sompayrac, Lauren M..... " "  
 Stamps, Walker..... " "  
 Strumpf, Irving J..... " "  
 Swift, Edwin C..... " "  
 Thomas, R. Y. H..... " "  
 Watt, E. Clements..... " "  
 Wattles, F. Merrill..... " "  
 Weil, Nathan, Jr..... " "  
 Weinreb, Joseph..... " "  
 Williams, Ashbel C..... " "

ESCAMBIA

Anderson, E. V..... Pensacola  
 Bell, John D..... " "  
 Click, Gustav N..... " "  
 Essrig, Irving M..... Tampa  
 Hixon, William P..... Pensacola  
 Kennedy, S. G..... " "  
 McSween, John C..... " "  
 Mellen, Noel C..... " "  
 Morse, George W..... " "  
 Randall, William S..... " "  
 Rubin, Nathan S..... " "  
 Stebbins, Alvin L..... " "  
 Tugwell, Wilton E..... " "  
 Turberville, Joe I..... Century  
 Williams, William L..... Pensacola

HILLSBOROUGH

Adamo, Frank S..... Tampa  
 Annis, Leonard S..... " "  
 Blackmon, Heyward J..... " "  
 Brown, Harold O..... " "  
 Chunn, C. Frank..... " "  
 Cole, Herschel G..... " "  
 Costantino, Eugene F..... " "  
 Cowart, James T..... " "  
 Grable, James S..... " "  
 Heath, Ralph T..... " "  
 Helms, John S..... " "  
 Hewit, Linus W..... " "  
 Knowlton, Horace A..... " "  
 Linz, Frank T..... " "  
 Martin, Douglas D..... " "  
 Mertz, R. Bradner..... " "  
 Murphey, David R..... " "  
 Nix, Harold G..... " "  
 Parsons, Hugh E..... " "  
 Rudisill, C. A..... " "  
 Ruskin, J. J..... " "  
 Torretta, Joseph N..... " "  
 Trice, William W..... " "

LAKE

Ashton, W. Lee..... Umatilla  
 Bowen, Louis R..... Eustis  
 Bowie, Clyde F..... Leesburg  
 Gleason, Albert H..... Umatilla  
 McGuire, John F..... Clermont  
 Oetjen, Leroy H..... Leesburg  
 Wood, Will L..... Eustis

LEE

Allan, Harry L..... Ft. Myers  
 Clement, W. B..... Punta Gorda  
 Girardin, A. L., Jr..... Ft. Myers  
 Jennings, John L..... Boca Grande  
 Stead, Vergil G..... Naples  
 Stipe, Harvie J..... Ft. Myers

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON

Andrews, Edson J..... Tallahassee  
 Clements, Merritt R..... " "  
 Ekermeyer, Ernest W..... " "  
 Holland, Francis T..... " "  
 Johnson, A. B..... Jamestown, N.Y.  
 Miles, W. G..... Chattahoochee  
 O'Connor, James B..... " "

MADISON-SUWANNEE

Black, Irby H..... Live Oak  
 Chappell, Frank V..... Madison

MANATEE

Floyd, Alva J..... Palmetto  
 Wentzel, W. E..... Bradenton

MARION

Cumming, Richard C..... Ocala  
 Harrell, Henry L..... " "  
 Lytle, Carl S..... " "  
 Moore, John P..... " "  
 Russell, Ralph E..... " "

ORANGE

Anderson, Claude ..... Orlando  
 Berry, Courtlandt D..... " "  
 Bichard, Phillip M..... " "  
 Butt, Thomas C..... " "  
 Chappell, J. Rocher..... " "  
 Christensen, Louis N..... " "  
 Crisler, George R..... Winter Park  
 Economou, James G..... Orlando  
 Gwathmey, G. Tayloe..... " "  
 \*Hatfield, John R..... " "  
 Henderson, Robert P..... " "  
 Hitchcock, Edgar E..... " "  
 Hoffmann, Carl D..... " "  
 Ingram, Hollis C..... " "  
 Irwin, Thomas M..... " "  
 Jewett, Eugene L..... " "  
 Kingsbury, Lawrence H..... " "  
 Kundert, Palmer R..... " "  
 Mathers, Fred..... " "  
 Mitchell, William S..... " "  
 Orr, Louis M..... " "  
 \*Osincup, Gilbert S..... " "  
 Ramsey, Russell W..... Winter Park  
 Robertson, Don C..... Orlando  
 Scanlon, John J..... Winter Garden  
 Sears, Warren H..... Winter Park  
 Sessions, Raymond R..... Kissimmee  
 Stecher, Joseph L..... Orlando  
 Sutter, Leroy M..... " "  
 Taylor, Byrne E..... " "  
 Zieve, Sanford L..... " "

PALM BEACH

Bippus, W. E..... West Palm Beach  
 Clarholm, Victor ... " "  
 Daly, Thomas E..... " "  
 Dawson, G. M..... " "  
 Derrick, C. J..... " "  
 Gill, Richard S..... " "  
 Herpel, F. K..... " "  
 James, Lorenzo, Jr. Camp Blanding  
 Kelley, Oscar L..... West Palm Beach

Nieder, James R..... Delray Beach  
 Ombres, S. Richard..... Palm Beach  
 \*Rotter, Saul D..... Lake Worth  
 Smith, Michael ..West Palm Beach  
 Sory, Bailey B..... Palm Beach  
 Sory, James R.. West Palm Beach  
 Stanley, Thomas Z..... " "  
 Weems, William H..... " "  
 Wilkins, William B..... Palm Beach

PASCO-HERNANDO-CITRUS

Manley, David B..... Zephyrhills

PINELLAS

Anderson, C. O..... St. Petersburg  
 Farber, William P..... " "  
 Farrington, C. L..... " "  
 Feaster, Orion O..... " "  
 Frederick, A. R..... " "  
 Funk, Neil E..... " "  
 Gable, Linwood M..... " "  
 Gable, N. W., Jr..... " "  
 Grace, Angus D..... " "  
 Groves, W. H..... Clearwater  
 Hagan, V. LeRoy..... " "  
 Hagood, John D..... " "  
 Harden, W. W..... St. Petersburg  
 Harrison, Everett M..... Dunedin  
 Hebard, Charles E. .... St. Petersburg  
 Langley, Francis H..... " "  
 McConnell, W. H..... " "  
 Marr, Norval M..... " "  
 Meyer, Francis P..... " "  
 Morin, H. Gerald..... " "  
 Murphey, Dan'l F. H.... " "  
 Needles, Robert J..... " "  
 Owen, R. Wynn S..... " "  
 Purcell, Thomas R. Tarpon Springs  
 Rogers, H. Milton .... St. Petersburg  
 Rowell, John P..... " "  
 Rudolph, Councill C.... " "  
 Ulm, A. Hardy ..... Dunedin  
 Whaley, F. Eugene .. St. Petersburg  
 Wood, Rowland E..... " "  
 Woodville, John B..... " "  
 Wright, Claude B..... " "  
 Wylie, LeRoy A..... " "

POLK

Annis, Jere W..... Lakeland  
 Barranco, Anthony J. Lake Wales  
 Bond, Benjamin J. .... Winter Haven  
 Bosworth, Joe M..... Lakeland  
 Clark, Samuel J..... " "  
 Dykes, Chapman ..... Haines City  
 Gachet, Fred S..... Lakeland  
 Hargrove, Julian L..... Bartow  
 Keramidas, T. C..... Winter Haven  
 Kibler, John M..... Lakeland  
 Lancaster, L. L..... Bartow  
 Martin, Emmett E..... Haines City  
 Ralston, Raymond H.... Lakeland  
 Tomlinson, J. Pitt, Jr., Lake Wales

PUTNAM

Bell, F. Emory ..... Palatka  
 Gurganious, Allen P..... " "

ST. JOHNS

Britt, Reddin ..... St. Augustine  
 Norris, Hardgrove S..... " "  
 Spencer, John ..... " "  
 Webb, Walter D..... " "



Dr. Elbert McLaury of Hollywood returned recently from a vacation in North Carolina.

Dr. B. F. Butler of Hollywood was recently called to North Carolina on account of the death of his father.

Dr. C. Harold Edmunds of Miami announces the removal of his office to 7501 Biscayne Boulevard, corner of N. E. 75th Street.

Dr. C. D. Whitaker of Marianna spent ten days at the Mayo Clinic during the month of August.

Miss Darthea McKibben of Coral Gables, daughter of Dr. W. W. McKibben, and Lieut. Col. Thomas Braddock Kreeger of Fort Benning, were married at Columbus, Georgia, on September 4.

Dr. Julian Gammon of Jacksonville spent the latter part of September in Boston and Baltimore where he visited clinics.

#### JOHN MARION WHITFIELD

Dr. J. M. Whitfield of Panama City died at the Veterans Hospital in Montgomery on August 14, at the age of 67.

Dr. Whitfield received his medical training at the University of Alabama, from which he was graduated in 1908. He was licensed to practice in Florida the following year. After locating in Panama City, many years ago, he founded the former Whitfield Hospital. During recent years his time was devoted mainly to the practice of obstetrics and gynecology. He took an active interest in local, civic, welfare and medical programs.

He was a member of the Bay County Medical Society, the Florida Medical Association and the American Medical Association.

#### CHARLES GREGORY GRIFFIN

Dr. Charles G. Griffin of Miami died suddenly in Nashville, Tennessee, where he was vacationing, on August 31. He was 61 years of age.

Dr. Griffin was a graduate of the University of Nashville, class of 1908. He practiced in Nashville for twenty-six years, moving to Miami in 1939, where he continued his practice. He was a member of the Judson Point Baptist Church of Nashville, the Dade County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are his wife, Mrs. Inez Graves Griffin; a daughter, Mrs. Jackson D. Rains of Jacksonville; a son, Charles G. Griffin, Jr., of Miami; and three step-daughters, Mary, Sarah and Martha Graves of Miami.

#### COMPONENT COUNTY SOCIETIES

##### DADE

The September meeting of the Dade County Medical Society was held at the Jackson Memorial Hospital, Miami, on Tuesday evening, September 7. A first aid demonstration was given by members of the local Office of Civilian Defense, under the direction of Mr. Chester Wright. Dr. Guy Stoddard then presented a paper on "Case Reports on Virus Pneumonias."

At the meeting of the society held on the evening of October 5, Dr. B. S. Kleinman was the principal speaker. He presented a paper on "Fundamentals of Electrocardiography and the Normal Electrocardiogram."

##### PASCO-HERNANDO-CITRUS

The regular meeting of this society was held Thursday evening, September 9, at the home of Dr. and Mrs. Claude L. Carter of Inverness. Senate Bill 1161, known as the Wagner-Murray Bill, was discussed at length, and opposed so vigorously that it was decided to have all members of the society write to their senators and congressmen outlining their objections.

The society went on record, by official action, as opposing the acceptance of the fee schedule submitted by the State Board of Health for maternal and infant care for families of U. S. soldiers.

The guest speakers of the evening were Dr. Eugene G. Peek, president of the State Association, and Dr. T. Hartley Davis of Ocala. Interesting talks were given by both speakers.

A cordial vote of appreciation was given to Dr. and Mrs. Carter for the delightful chicken dinner and splendid entertainment which preceded the scientific meeting.

By invitation of Dr. W. B. Moon, the society decided to hold its next regular meeting at Magnolia Lodge, Crystal River, on October 14. The following members were present: Drs. J. T. Bradshaw, San Antonio; G. R. Creekmore, Brooksville; Claude L. Carter, Inverness; S. C. Harvard, Brooksville; P. J. Hudson, Crystal River; W. Wardlaw Jones, Dade City; W. B. Moon, Crystal River; Eugene G. Peek and T. Hartley Davis, Ocala.

#### PINELLAS

On the evening of September 17, the Pinellas County Medical Society held a round table assembly at the home of Dr. Howard Bucknell. The subject discussed was "Pediatrics." Military medical officers and nurses were guests at this meeting.

#### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville 1, for abstracting in this department.*

**RENAL COUNTERBALANCE IN RELATION TO CONSERVATIVE RENAL SURGERY, ORR, LOUIS M., AND KUNDERT, PALMER R., ORLANDO, SOUTH. M. J. 35: 723-729 (AUG.) 1942.**

The physiologic interrelation as well as the pathologic response of one kidney to the other in their ability to exchange their functional burden is what is known as renal counterbalance. In reporting a case the authors give a brief review of the present day conception of renal counterbalance.

A white woman, aged 57, whose chief complaint was a pain in the right flank radiating toward the bladder, was seen in January, 1933. Cystoscopic examination revealed residual urine in the right renal pelvis. Pyelograms showed a normal left kidney and pyelectasis and calyctasis of the right kidney suggesting an obstruction near the ureteropelvic junction. A right nephropexy with lysis of ureteral adhesions was carried out. Recovery was uneventful, and an estimation of

the functional output of the right kidney showed improvement. A roentgenogram revealed a return to normal of the previously dilated pelvis and calyces.

Three and one half years later the patient was again seen. A cystoscopic examination with functional estimations and pyelograms showed an advanced hydronephrosis of the left kidney with greatly reduced elimination of dye. Pyelograms revealed a classical hydronephrosis and suggested the presence of an aberrant vessel at the ureteropelvic junction. A left nephropexy was performed and an aberrant vein at the ureteropelvic junction was ligated. Convalescence was uneventful. Elimination tests showed that the output of the right kidney was normal whereas that of the left kidney remained diminished. Pyelograms showed a return to normal of the left kidney though its function remained abnormal.

This case seems to present evidence that the opposite kidney may undergo compensatory hypertrophy. The observation of the functional behavior of the two kidneys under the clinical trial of obstruction with subsequent surgical relief would seem to substantiate the theory of renal counterbalance.

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**TREATMENT OF MINOR INJURIES, NETTO, LLOYD J., WEST PALM BEACH, SOUTH. M. J. 35: 750-756 (AUG.) 1942.**

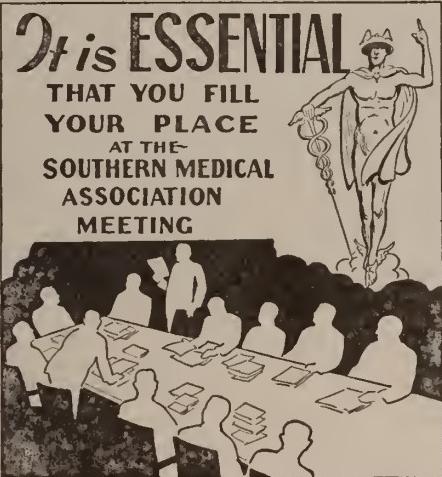
In this paper the author describes the treatment of minor injuries encountered in office practice. For a sprained ankle in which various ligaments are stretched or torn, cold applications are applied, the foot is elevated, and complete immobilization is accomplished by applying elastic bandages. Roentgen examination to exclude a possible fracture is recommended in all cases.

For a puncture wound caused by a nail the author recommends thorough cleansing, the application of a disinfectant, infiltration with procaine, incision of the wound to expose and remove foreign bodies, and drainage. He administers tetanus antitoxin routinely.

Dog bites he treats by cauterization with fuming nitric acid. Antirabic vaccine is given only when the patient has been bitten by a rabid dog.

For traumatic ulcers of the leg, application of silver nitrate, zinc oxide ointment and pressure bandages are recommended.

The author reports that during the past year



MEDICAL MEETINGS ARE ESSENTIAL, as essential in wartime as in peace, even more so. Physicians, military and civilian, need medical meetings, for it has been well said that "it is important that medicine not be frozen for the duration," and that "we must preserve and disseminate advances in medicine as never before." An essential meeting is the Southern Medical Association, Cincinnati, Ohio, Tuesday, Wednesday, Thursday, November 16-17-18. The Cincinnati meeting has been streamlined to meet wartime conditions, essential medicine brought down to date—a great wartime meeting. The Southern Medical Association is meeting in Cincinnati upon the invitation of the Campbell-Kenton County Medical Society of Kentucky. Newport and Covington are the principal cities of this two-county society and are across the river from Cincinnati. It is a Kentucky meeting.

REGARDLESS of what any physician may be interested in, of how general or how limited his interest, and whether in military or civilian practice, there will be at Cincinnati a program to challenge that interest and make it worth-while for him to attend.

ALL MEMBERS of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

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he obtained good results in treating minor burns with "Foille."

He stresses that the most important step in the treatment of any laceration is the removal of all particles of dirt, together with debridement and suture if necessary. He emphasizes that even in small lacerations a careful inspection should be made to ascertain whether there are additional underlying injuries such as the severance of tendons, or bone fracture.

The author recommends the use of sulfanilamide and sulfathiazole ointment and powder as prophylactic and therapeutic agents.



ANESTHESIA FOR THE AGED, FORASTIERE, ROGER J., MIAMI, J. CONNECTICUT M. SOC. 7: 243-250 (APR.) 1943.

Anesthesia was administered to 280 patients 60 years of age and over. For preoperative sedation morphine sulfate with scopolamine hydrobromide was given.

Inhalation anesthesia was used in 70 per cent of the cases and regional anesthesia, or pentothal sodium in the others. Cyclopropane was the agent of choice, especially when lengthy operative procedures were anticipated.

In the cases in which regional anesthesia was employed, 71 per cent were by spinal puncture and 29 per cent by either procaine infiltration or nerve block.

Although the number of cases presented is small, the conclusions corroborate the impression gained from clinical experience with these patients. The author points out that age is not a sound criterion on which to base the anesthetic management of elderly patients. It is important to gain an accurate picture of the patient's physical status, especially of the organs of circulation, respiration and excretion. Preoperative treatment to raise the vital functions to their highest possible efficiency is important, because the anesthetic problem encountered in the aged is not that of age itself but of complicating diseases.

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## ADVERTISERS' NOTES

## AMEBIASIS

The incidence of amebiasis has been shown to be greater than was formerly supposed, and there is reason to believe that the disease may become even more prevalent when large numbers of troops begin to return home from the tropics. Surveys collected before the war revealed that more than one in ten subjects harbored *E. histolytica*. It would seem reasonable, therefore, that whenever intestinal symptoms form a part of the clinical picture, the diagnosis should not be considered complete until the possibility of amebiasis has been ruled out. Chronic, uncomplicated intestinal amebiasis is the most frequent type, and it includes the carrier as well as the individual with recurrent or mildly persistent symptoms. Pulvules Carbarsone, Lilly, each containing 0.25 Gm., may be given orally at the rate of one pulvule two or three times daily to a total of twenty doses (5 Gm.). This routine may ordinarily be repeated several times, provided intervals of ten days are allowed between courses and the urine and liver show no evidence of damage. Bed rest is not necessary in this group.

ample of the greatly increased scientific progress being made today in the chemical and pharmaceutical industries. It indicates the kind of investment in co-operative scientific research that must be made from time to time by leading organizations in these fields.

## NEW ETHICON EYE SUTURES DEVELOPED BY

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As a result of several years research a new and complete line of seventeen Eye Sutures has just been announced by the Ethicon Suture Division of Johnson & Johnson.

The new Ethicon Eye Sutures, offered in Plain and Type B Mild Chromic Surgical Gut, as well as Twisted Silk, are distinguished by their unusual flexibility.

All Ethicon Eye Sutures are equipped with Eyeless Atraloc Cutting Point Needles. These needles, made under a Johnson & Johnson patent, are hand forged and hand sharpened. All materials in Ethicon Eye Sutures are selected to meet the exacting requirements of the Eye surgeon.

## A GRANT FOR THE STUDY OF PENICILLIN

The Board of Trustees of the University of Illinois have announced the acceptance of a grant of \$25,000 a year for three years made by The Upjohn Company of Kalamazoo, Michigan, to be devoted to the academic study of the structural composition and possible synthesis of penicillin.

The Company's present grant, says F. W. Heyl, Ph.D., Vice President and Director of Research, provides for an enlarged three-year research chemistry project under the direction of Professor Herbert E. Carter of the department of biochemistry at Urbana, Illinois. This, says Heyl, amplifies both an earlier cooperative research project at that school and the bacteriologic and other research which is being conducted at the Company's laboratories at Kalamazoo.

Dr. Carter is well known for his brilliant work with the amino acids, especially for the identification and synthesis of the new essential amino acid, threonine, and more recently for his investigations on the structure of the cerebroside sphingomyelin.

The production of penicillin by the natural growth of the mold *Penicillium notatum* is one of the most laborious and unsatisfactory methods in use for the manufacture of any known therapeutic agent. The hope of the future for the large scale economical manufacture of this important drug lies in the solution of the pure chemistry which alone would lead to the chemical synthesis of the substance. It is in the hope of achieving this end that the Upjohn penicillin fellowship at the University of Illinois has been established.

This grant of the Upjohn Company is a good ex-

## PARKE-DAVIS SPEEDS PRODUCTION OF PENICILLIN

A streamlined process of penicillin production, resulting from two years' research in the Parke-Davis Laboratories, promises to substantially cut down the production time required, according to Homer C. Fritsch, General Manager of the Company.

"The present method of producing penicillin requires from 6½ to 14 days," he said in an interview recently. "We have advanced our methods to where we can produce in 2½ to 3 days without using cumbersome equipment."

This constitutes a significant forward step, since the bottle-neck in the penicillin situation, to date, has been the fact that the drug has been available only in comparatively small amounts. Parke-Davis & Company is now regularly supplying penicillin to the government and has recently expanded its facilities for producing the new "miracle" drug.

## THE MEAD JOHNSON VITAMIN B COMPLEX AWARD

Nominations are solicited for the 1944 award of \$1,000 established by Mead Johnson and Company to promote researches dealing with the B complex vitamins. The recipient of this award will be chosen by a committee of judges of the American Institute of Nutrition. The award will be given to the laboratory (non-clinical) or clinical research worker in the United States or Canada who, in the opinion of the judges, has published during the previous calendar year January 1 to December 31 the most meritorious scientific report dealing with the field of the B complex vitamins. While the award will be given primarily for publication of specific papers, the judges are given considerable latitude in the exercise of their function. If in their judgment circumstances and justice so dictate, it may be recommended that the prize be divided between two or more persons. It may also be recommended that the award be made to a worker for valuable contributions over an extended period but not necessarily representative of a given year. Membership in the American Institute of Nutrition is not a requisite of eligibility for the award.

To be considered by the committee of judges, nominations for this award for work published in 1943 must be received by the secretary, Arthur H. Smith, Ph.D., Wayne University College of Medicine, Detroit, by Jan. 10, 1944. The nominations should be accompanied by such data relative to the nominee and his research as will facilitate the task of the committee of judges in its consideration of the nomination.

## LECTURES ON TROPICAL MEDICINE

At the invitation of the Pan American Sanitary Bureau, Dr. Olympio da Fonseca, Jr., medical director for Brazil of E. R. Squibb and Sons Inter-American Corporation, has arrived in the United States for an extensive lecture tour. He is appearing before the faculties and students of medical schools throughout this country, discussing tropical medicine with special emphasis on malaria, African sleeping sickness, amebic dysentery and ringworm infection.

Dr. da Fonseca is a professor at the National School of Medicine of the University of Brazil and is connected with the Medical Centre of Ceara and the Department of Health of that state. He has attained world-wide re-



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MEDICINE—Courses to be announced in January.

FRACTURES & TRAUMATIC SURGERY—Courses to be announced in January.

GYNECOLOGY—Two weeks Intensive Course starting February 7th. One week Personal Course in Vaginal Approach to Pelvic Surgery starting November 1st. Clinical and Diagnostic Courses.

OBSTETRICS—Two weeks Intensive Course starting February 21st.

ANESTHESIA—One week Course in Continuous Caudal Anesthesia for Obstetrics.

OPHTHALMOLOGY—Clinical Course.

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nown as a mycologist, both as teacher and as director in this field at the Institute of Manguinhos. He is the author of the textbook "Medical Parasitology."

Dr. da Fonseca's lecture schedule includes Syracuse University College of Medicine, Syracuse, N. Y.; University of Rochester School of Medicine, Rochester, N. Y.; University of Buffalo School of Medicine, Buffalo, N. Y.; University of Pittsburgh School of Medicine, Pittsburgh, Pa.; Western Reserve University School of Medicine, Cleveland; Wayne University School of Medicine, Detroit; University of Michigan Medical School, Ann Arbor; Ohio State University College of Medicine, Columbus; University of Cincinnati College of Medicine, Cincinnati; University of Louisville School of Medicine, Louisville; University of Tennessee College of Medicine, Memphis; University of Arkansas School of Medicine, Little Rock; Baylor University College of Medicine, Dallas, Texas; University of Texas Medical Branch, Galveston, Texas; University of Oklahoma School of Medicine, Oklahoma City; University of Kansas School of Medicine, Lawrence-Kansas City; University of Nebraska College of Medicine, Omaha; Creighton University School of Medicine, Omaha; State University of Iowa College of Medicine, Iowa City; University of Minnesota Medical School, Minneapolis; University of Wisconsin Medical School, Madison, Wis.; Marquette University School of Medicine, Milwaukee; Loyola University School of Medicine, Chicago; Northwestern University Medical School, Chicago; University of Chicago, The School of Medicine, Chicago; University of Illinois College of Medicine, Chicago.

#### FURTHER EXPANSION OF AMERICAN HOME PRODUCTS CORP.

The formation of Wyeth, Incorporated, as one of the nation's largest ethical drug houses through the grouping of seven companies now operating in the pharmaceutic, biologic and nutritional fields, was announced recently by American Home Products Corporation, of which the new company will be a wholly-owned subsidiary.

The companies which will comprise Wyeth, Incorporated, include some of the oldest and most important units in the ethical drug industry. They are John Wyeth and Brother, Incorporated, of Philadelphia, 83-year-old manufacturer of pharmaceutics; S.M.A. Corporation of Chicago, Illinois, and Mason, Michigan, producers of products for infant nutrition; the Reichel Laboratories, Inc., of Kimberton and West Chester, Pa., one of the largest producers of blood plasma for the Armed Forces and manufacturer of biologics, the Bartos system of allergenic protein diagnostics and a pioneer in the development of the new wonder drug, penicillin; Gilliland Laboratories, Inc., of Marietta, Pa., manufacturers of a comprehensive line of biologics; Petrogalar Laboratories, Inc., of Chicago, makers of Petrogalar; General Biochemicals, Inc., of Chagrin Falls, Ohio, manufacturers of vitamins, and The Bovinine Company of Chicago, products for anemia.

Reichel Laboratories, which is now one of the nation's largest producers of penicillin, has been authorized by the government to spend \$532,831 on new facilities to increase its production of this drug.

The combination of these companies to function as one big ethical drug house climaxes the steady expansion of American Home Products Corporation in the ethical drug field. All seven companies are at present subsidiaries of American Home Products, two of them having been acquired over the past year.

Through John Wyeth and Brother, the new company will have a world-wide operation with plants in England, Canada, Argentina, Australia, New Zealand and South Africa.

#### SUN GLASSES AND GOGGLES FOR OUR FIGHTERS

A total of 2,412,000 pairs of eye-protecting sun glasses and goggles were delivered to the Army and Navy, by the American Optical Company during the period from January 1 to September 20, C. O. Cozzens, vice-president, recently announced.

He said the sun glasses and goggles, comprising different types, are issued to all branches of the service—tank and motorized corps, gunners, fliers, infantrymen, sailors and marines—who wear them for protecting their eyes against dust, glare, wind, water, and for improving their marksmanship.

A recent shipment, he added, consisted of 225,000 pairs of sun glasses, the largest single shipment on record.

#### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

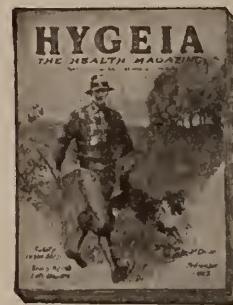
HANDBOOK OF TROPICAL MEDICINE. By Alfred C. Reed, M. D., Associate Clinical Professor of Medicine, Stanford University School of Medicine, and J. C. Geiger, M. D., Director of Public Health, San Francisco, Calif. Cloth. Price, \$1.50. Pp. 188. Stanford University, Calif.: Stanford University Press, 1943.

THE MIND OF THE INJURED MAN. By Joseph L. Fetterman, M.A., M.D., Assistant Clinical Professor of Nervous Diseases, Western Reserve University School of Medicine, Cleveland. Cloth. Price, \$4.00. Pp. 260, with 28 illustrations. Chicago: Industrial Medicine Book Company, 1943.

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## WAR SERVICE PROGRAM

The following program has been sent to us by our national chairman, Mrs. Rollo K. Packard, who expresses the hope that every auxiliary member will acquaint herself with the War Service Program which has been approved by the National Advisory Council, and recommended to state and county auxiliaries as a major project for the coming year.

In developing this program, our first thought is that each member of the Auxiliary, as an American citizen, must assume her responsibility in the total war effort. It should be remembered, however, that we function as an auxiliary to the American Medical Association and not as an independent organization. Therefore, our program of war activities, as an Auxiliary, should be largely one of assistance to them in their excellent programs now established.

Since our entry into World War II, most of us have made individual and collective contributions to the various war service programs in our own communities. Many of the state and county auxiliaries have already developed plans that are worthy of study and consideration. It is impossible for the War Service Committee to make plans that are applicable to all states and to all counties. It is hoped that from a study of the general program here presented and from the accomplishments of other auxiliary groups, every auxiliary will be able, under the guidance of its local advisory committee, to develop a successful program for war service. Auxiliaries should work as closely as possible with the state war participation committees or with similar committees of the constituent state medical associations.

Let us consider ways and means in which the Auxiliary can assist our country in its programs that are essential to winning the war, and to our doctors in giving adequate medical care to our armed forces and to the civilian population; also how we can help the doctors in service and their families. Finally, we must consider rehabilitation in its various phases.

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**COMPONENT SOCIETIES BY DISTRICTS**

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	J. Powell Adams, M.D. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		13	12	A-1-45 C. D. Whitaker, M.D. Marianna
Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	48	100%	
Franklin-Gulf		J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	5	100%	
Jackson *Calhoun	R. N. Joyner, M.D. Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	100%	
Walton-Okaloocha	A. G. Williams, M.D. Lakewood	R. R. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	6	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	100%	
Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	James W. Sapp, M.D. Havana	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 8:00 P.M.	40	39	
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		7	100%	
Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	G. H. Warren, M.D. Perry	Last Friday 8:00 P.M.	5	4	
Alachua *Bradford, Gilchrist, Union	Geo. C. Tillman, M.D. 505 W. University Gainesville	Chester F. Ahmann, M.D. 1043 W. Masonic Gainesville	2nd Wednesday 7:30 P.M.	28	25	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
Duval *Clay	T. Z. Cason, M.D. 2033 Riverside Ave. Jacksonville, 4	F. A. Corp, M.D. 411 St. James Bldg. Jacksonville 2	1st Tuesday 8:15 P.M.	194	192	
Marion *Levy	T. Hartley Davis, M.D. 202 Commercial Bk. Bldg. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	28	27	
Nassau	Geo. A. Dame, M.D. Fernandina	E. F. Waite, M.D. Fernandina	2nd Wednesday 8:00 P.M.	9	100%	
Putnam	J. Worth Brantley, M.D. Grandin	C. M. Knight, M.D. Palatka	2nd Tuesday Even Months 7:00 P.M.	9	100%	
St. Johns	Alfred W. Norris, M.D. Flagler Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	G. E. Christie, M.D. Rox 151 Titusville	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	100%	
Lake *Sumter	Louis R. Bowen, M.D. Eustis	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	100%	
Orange *Osceola	T. E. McBride, M.D. Apopka	John A. Pines, M.D. 106 E. Central Ave. Orlando	3rd Wednesday 8:00 P.M.	90	85	
Seminole	Geo. H. Putnam, M.D. Touchton Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	L. von Meysenbug, M.D. Box 3356 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	43	41	
Hillsborough	T. C. Maguire, M.D. 104 S. Collins St. Plant City	Curtis B. Jefferson, M.D. 818 First Nat. Bk. Bldg. Tampa 2	1st Tuesday 8:00 P.M.	106	100	C-5-44 Leland F. Carlton, M.D. Tampa
Manatee	M. M. Harrison, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	14	100%	
Pasco-Hernando- Citrus	W. W. Jones, M.D. Dade City	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	11	100%	
Pinellas	J. A. Hardenhergh, M.D. 404 Power & Light Bldg. St. Petersburg 4	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg 4	1st and 3rd Fridays 6:30 P.M.	104	102	
Sarasota	O. H. Cribbins, M.D. 138 N. Link Sarasota	A. O. Morton, M.D. Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	19	100%	
DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	100%	
Lee *Collier, Hendry	H. Quillian Jones, M.D. 18 Leon Bldg. Fort Myers	W. H. Grace, M.D. Box 907 Fort Myers	3rd Tuesday 7:30 P.M.	17	100%	
Polk	T. G. Simmons, M.D. Corlett Bldg. Auburndale	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	62	100%	
Palm Beach	K. Montgomery, M.D. Guaranty Bldg. W. Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	4th Monday 8:00 P.M.	68	64	D-7-45 William Y. Sayad, M.D. West Palm Beach
St. Lucie- Okeechobee-Indian River-Martin	Francis A. Gowdy, M.D. Box 745 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	100%	
Broward	D. W. Harris, M.D. 420 Sweet Bldg. Ft. Lauderdale	O. C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	2nd Wednesday 8:00 P.M.	41	100%	
Dade	H. L. Pearson, M.D. 416 Ingraham Bldg. Miami	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami	1st Tuesday 8:30 P.M.	338	323	
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P.M.	5	100%	

\*Supervise and aid until organized separately.

1. We must maintain an adequate army and navy. As auxiliary members we must feel that there is little we can do regarding this. However, our active support of those agencies that are responsible for the development of the army and its maintenance is most valuable.

2. Munition and implements of various kinds needed in modern warfare must be furnished to our army and navy. The Auxiliary can, undoubtedly, be of assistance in highly developed industrial communities by cooperation with the industrial health program of the A. M. A. to the end that the health of the industrial workers is maintained and that those who are ill or injured may be speedily returned to their occupation.

3. The armed forces, as well as the civilian population, must be properly fed. Constant education in nutrition is of value to the civilian population and necessarily we must make some sacrifices to the end that our armed forces have the proper food.

4. Efficient transportation of the armed forces is important. There seems little the Auxiliary can do about this, and yet one of the most important problems we have at home is the conservation of our transportation facilities. The less we use them and the more we influence other people not to use them, the more we can aid the movement of troops.

5. Money must be raised to carry on the war, and the Auxiliary can be of distinct value in the selling of war stamps and bonds.

6. The best medical care must be available for the armed forces. The doctors are already doing that, and there is little the Auxiliary can do except whatever influence they may exert in those states where the medical quota has not been reached.

7. The best type of medical care must also be provided for the civilian population. Under this we must consider the civilian population as a whole, the industrial communities that have grown rapidly, the shortage of hospital facilities and doctors and the manning of our hospitals with nurses and nurses' aids to carry on the work and emergency changes. The various agencies concerned with the procurement of nurses for the armed force and for civilian life are asking for 65,000 high school graduates to enlist in an accelerated nurses' training program. This is one of the greatest fields of active work now possible for the Auxiliary. Contact your local hospitals and ascertain how you can best serve them.

8. Make an effort to provide some entertainment for medical officers and their families stationed in or near your city. Many of these men would appreciate addressing the Auxiliary and being invited to medical meetings. The names and addresses of these medical officers may be secured from the commanding officer of the camp or fort. Inquire as to what assistance the Auxiliary could be to the medical officers and their families.

9. We should give special attention to the wives and families of the medical men who are now in service; not only that they have proper medical care but a special interest should be taken in their general welfare and their entertainment. They are making a very definite sacrifice and we should show our appreciation in every way possible.

10. In cities adjacent to camps and forts, special recreation rooms should be provided for medical officers, so that they will not have to depend on the quarters now being used by other men in service.

11. Have a central location where all communications may be received which may be either the office of the county medical society or the doctors' recreation rooms.

12. We must maintain our present standards of medical education and training. Constant educational programs should be carried on so that the public will realize the necessity of maintaining our present standards.

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**STATE AND SECTIONAL MEETINGS**

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Eugene G. Peek, Ocala .....	Shaler Richardson, Jacksonville.....	To Be Announced
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna .....	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville .....	" " "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland .....	" " "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach .....	" " "	Miami, Postponed
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa .....	D. L. Cannon, Montgomery.....	Montgomery, Apr. 18-20, 1944
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	Savannah, May 9-12, 1944
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg .....	Kenneth Phillips, Miami .....	To Be Announced
Dental Society, State .....	A. Malcolm Smith, D.D.S., Tampa .....	H. L. Cartee, D.D.S., Miami .....	Jacksonville, Nov. 10, 11, 1943
Derm. and Syph., Soc. of .....	Wiley M. Sams, Miami .....	Lauren M. Sompayrac, Jacksonville .....	Miami, October, 1943
East Coast Medical Association.....	T. C. Kenaston, Cocoa .....	I. M. Hay, Melbourne .....	Postponed
Hospital Association .....	Mr. W. E. Arnold, Jacksonville .....	Miss Katharine Moyer, Lake Wales .....	
Industrial Surgeons, Assn. of .....	Frank D. Gray, Orlando .....	Richard H. Walker, Orlando .....	To Be Announced
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville .....	Chairman .....	
Nurses Association, State .....	Mrs. Ann Thompkins, Leesburg .....	Miss Madalee Hazel, St. Petersburg .....	To Be Announced
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville .....	C. E. Dunaway, Miami .....	To Be Announced
Pathological Society.....	L. Y. Dyrenforth, Jacksonville .....	Iva C. Youmans, Miami .....	To Be Announced
Pediatric Society .....	Ludo von Meysenbug, Daytona B. ....	Robert Blessing, Ft. Lauderdale .....	To Be Announced
Pharmaceutical Association, State .....	Mr. H. B. Douglas, Bonifay .....	Mr. R. Q. Richards, Ft. Myers .....	Miami, To Be Announced
Public Health Association .....	Leland H. Dame, Sanford .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	John N. Moore, Ocala .....	Walter A. Weed, Orlando .....	To Be Announced
Railway Surgeons' Association .....	Frank D. Gray, Orlando .....	W. C. Page, Cocoa .....	To Be Announced
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales .....	Mrs. May Pynchon, Jacksonville .....	
Chattahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine .....	Robert B. McIver, Jacksonville .....	Postponed
Gulf Coast Clinical Society .....	G. G. Oswalt, Mobile, Ala. ....	C. L. Rutherford, Mobile, Ala. ....	Postponed
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola .....	Kenneth Phillips, Miami .....	
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta .....	Postponed
Southern Medical Association .....	Harvey F Garrison, Jackson, Miss. ....	Mr. C. P. Loranz, Birmingham .....	Cincinnati, Nov. 16-18, 1943
Suwannee River Medical Society .....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City .....	



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\*Himes, *Medical History of Contraception*

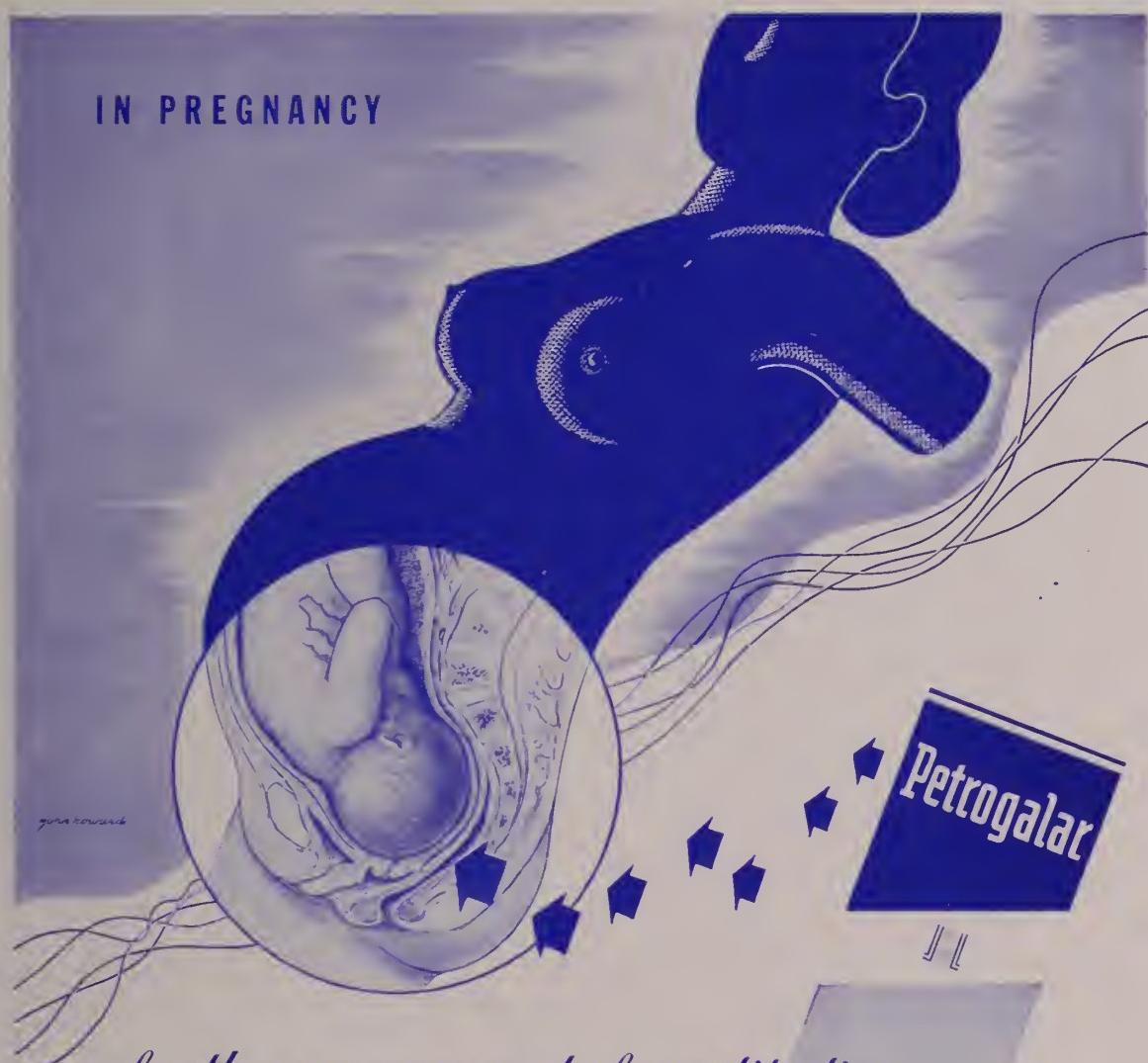


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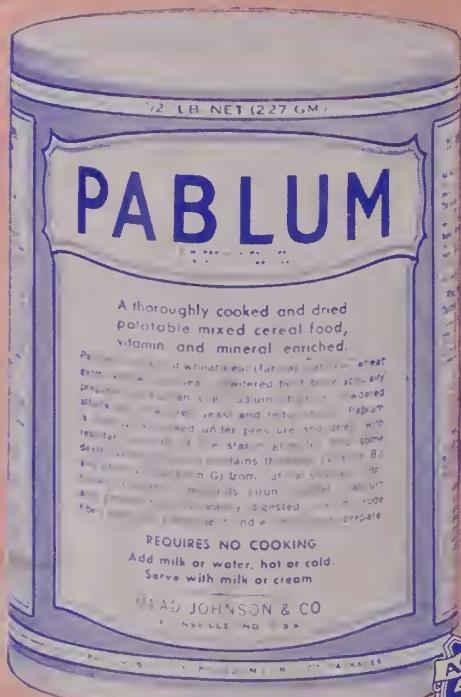
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# The JOURNAL of the Florida Medical Association, Inc.

Vol. XXX

DECEMBER, 1943

No. 6

THE FLORIDA ACADEMY  
OF MEDICAL SCIENCE

DEC 12 1943

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## HOW CAN A DOCTOR HAVE A MERRY Christmas?

You are a healer, a saver of life . . .

Yet, this Christmas you see a world intent on maiming, on killing.

You wish you were out where the wounded and dying are, doing everything in your power for them . . .

But, circumstance holds you and commands, "Stay, do your work here—where the need for it is greater than ever before!"

Because today twice as many people are dependent upon your skill, no hour of day or night is completely and certainly your own...

Not even at Christmas.

So, to wish you a *merry* Christmas at this time would be to wish you the impossible.

However, the House of Wyeth—dedicated, too, to the relief of suffering—does wish that

on Christmas Day you find a moment to yourself . . .

To hope, to believe, that this time the maiming and killing of war are being endured for the last time . . .

To be thankful for the wonderful healers and healing techniques that are coming out of the war to serve the peace . . .

To take pride in the glorious achievements of your professional brothers in uniform . . .

And to feel that your own service, wearying and unheroic though it be, is appreciated—and in the finest traditions of the selflessness of the medical profession.

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Box 1018  
Jacksonville, 1, Fla. Telephone 5-0577

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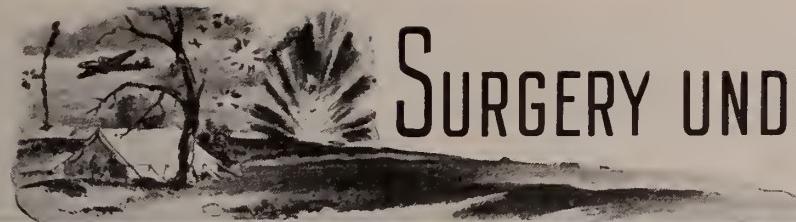
\*Himes, *Medical History of Contraception*

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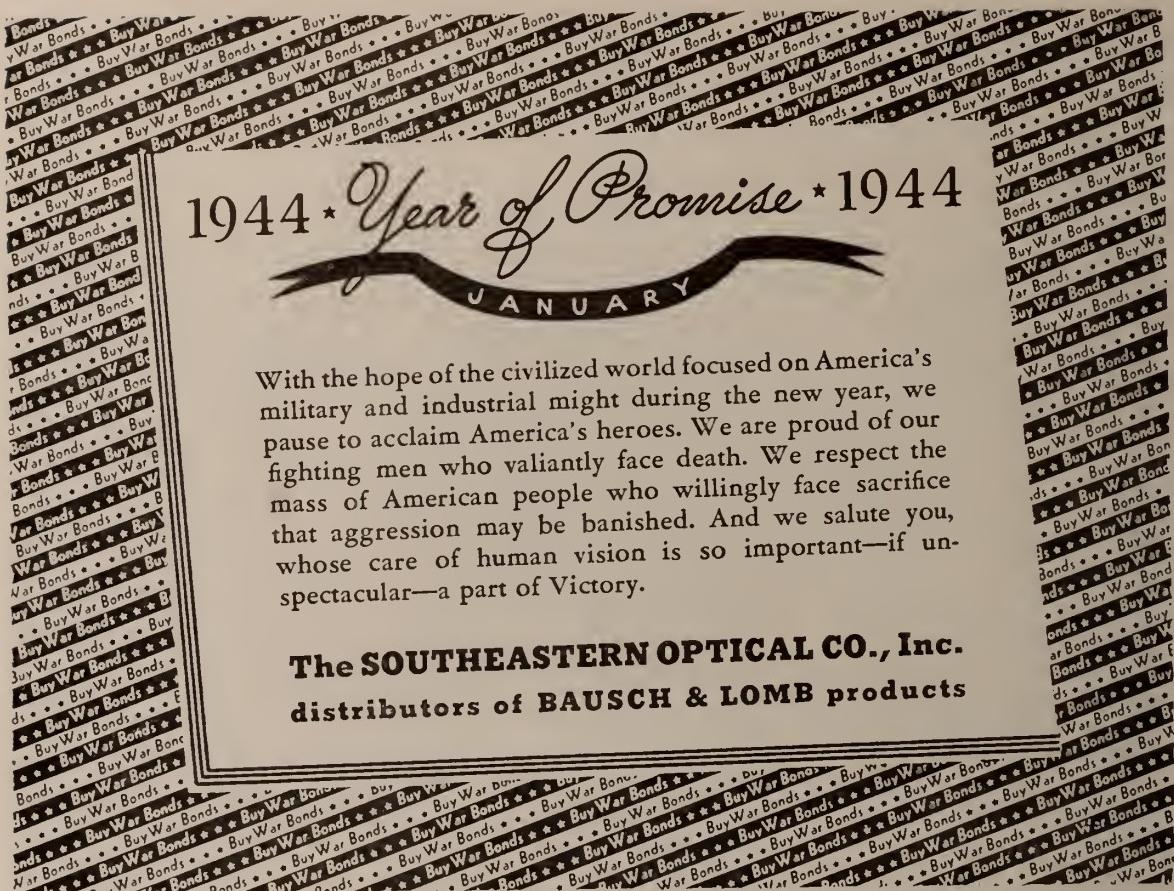
\*With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)



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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

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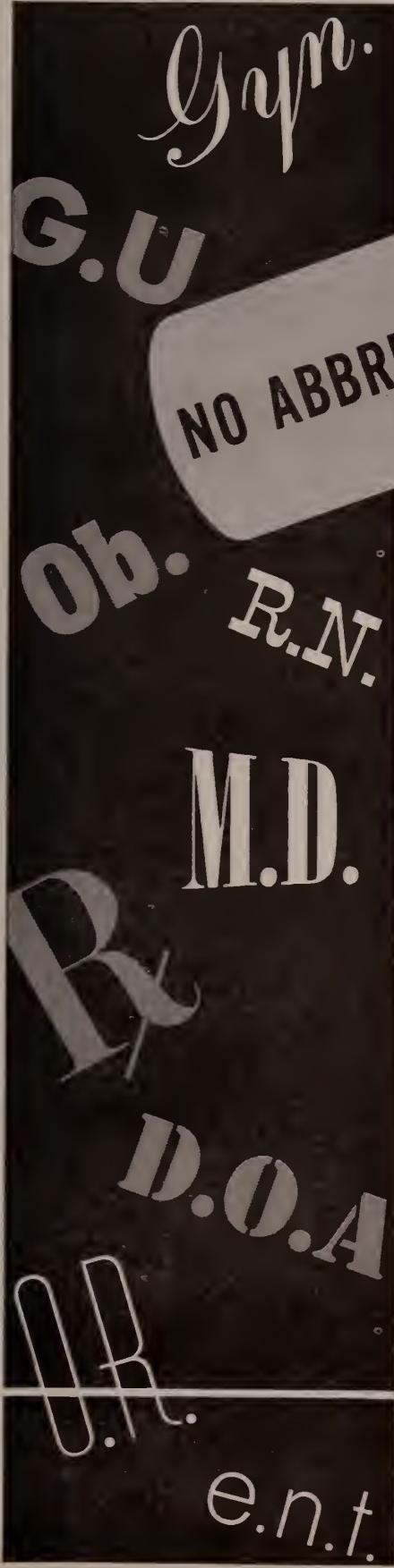
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\**Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.*

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- 190 Private mental patients who PAID a PORTION of regular rates ACCORDING to their ABILITY TO PAY.
- 10 Private mental patients who PAID NOTHING.  
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- 573 Mental patients or 55.84% of a total of
- 1062 Mental patients treated, WERE SUCCESSFULLY TREATED and RETURNED to THEIR FAMILIES, a DISCHARGE RATIO of 558 patients per
- 1000 mental patients under treatment, whereas the United States Public Health reports state "13 OF EVERY 100 PATIENTS under treatment in PUBLIC HOSPITALS in the United States WERE DISCHARGED during the year."

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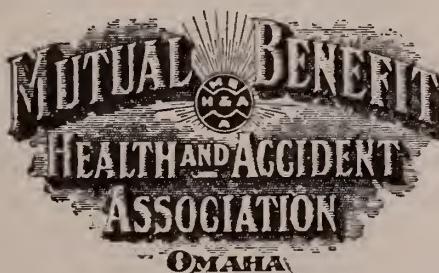
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## ON THE FOXGLOVE

THEODORE F. HAHN, M. D.  
DE LAND

When digitalis was first introduced to the medical profession by Withering in the latter part of the eighteenth century, its action on the heart was not fully appreciated. It was first used because of its diuretic powers in cases of dropsy. Subsequent observers brought out the importance of its cardiac action. Among these were L. MacLean and W. Hamilton. These men, though much acquainted with the results of its administration, had little understanding of its pharmacologic actions. MacLean left a treatise on hydrothorax which includes mention of all conditions that may cause effusions into the serous cavities; one chapter is devoted to the consideration of digitalis and its effects on such effusions. It is my purpose in this paper to review these early considerations and recall to mind one whose observations were careful, thorough and worthy of commemoration. The book from which the discussion is taken is the first American edition of "Hydrothorax" by L. MacLean, printed and sold by Hale and Hosmer of Hartford, in the year 1814.

MacLean considered that digitalis has six effects on the body. It is evident that a number of the actions he described were due to toxic doses so that in his observations he included not only the pharmacologic but also the toxicologic effects of the drug. (1) "*Effects on the sensorium* are such as vertigo, giddiness, throbbing of the orbits, headache and later delirium, or impaired intellectual functions." This action on the central nervous system exists, though it is not evident following the usual therapeutic doses. (2) "*Effects on the heart* are reduction of the number of contractions of the heart, frequently an intermission, irregularity and quickness of the pulse." Here he obviously described the effects of varying doses. Cushney described these as the first, second and third stages of the action of digitalis on the heart. (3) "*Effects on the stomach* are nausea, sickness and vomiting," which are now known to be symptoms of over dosage or intolerance due to cumulative effects, chiefly stimulation of medullar centers, but also

to direct irritation of the gastric mucosa by large doses.

(4) "*Effects on the bowels* are watery evacuations," which are not a direct effect, but, as MacLean asserted, occur only when there is much dropsy. This result is probably related to medullar stimulation, but the disturbance in excretory mechanisms when large volumes of fluid are suddenly released may have some bearing on this response. (5) "*Effects on the secretions and excretions* cause an increased flow of urine and perhaps of saliva." MacLean contended that this effect results only when digitalis is exhibited in the dropsy and credited this observation to Withering "because he was the first to prescribe it as a remedy in the dropsy . . . some indeed positively affirm that in diseases unaccompanied with serous effusions in which they carried it to the fullest extent, it produced no increased flow of urine." Such diuretic effects are not due to any specific action on the kidney, but to the increased force and volume of flow of the circulation, which of course will not be great if there is no dropsy. (6) "*Effect on the general habit* is the production of languor, weakness, faintness, coldness and sweats." These are present in acute or severe digitalis poisoning.

The early observers, then, recognized that they were dealing with a potent drug which had a beneficial effect in certain conditions of cardiac failure, but that they were giving toxic doses and causing digitalis poisoning was not evident to them. MacLean summarized the effects in these words, ". . . its constant effects being those on the head, heart, stomach and animal functions, whereas those on secretions, etc. will arise only in particular circumstances, namely, when watery fluids are preternaturally effused in cavities . . ." The drug was not tried on healthy subjects.

In the main, the discussion of digitalis in those days concerned itself not so much with the pharmacology of the drug as with its proper place in the pharmacopeia of the times. The great question was whether or not digitalis belongs to the sedative group of drugs. MacLean considered it to be a sedative and built up an argument to prove his contention. The argument is interesting and ingenious. On the opposite side, the statement of a Dr. Beddoes seems to me one

of the clearest for the time, "Digitalis in carefully regulated doses so administered as not to induce sickness or languor very regularly increases the momentum of the blood." This is an acute observation. In fact, it is the key to the rational use of digitalis, which, if it had been properly emphasized, might have early clarified the confusion regarding the drug. Note the word "momentum," which is applied to the tonic action of digitalis. Beddoes then discussed the irritability of the heart and stomach from increasing doses of digitalis, citing a case in which the pulse rate went to 120 every time the patient was put on 14 drops of digitalis twice a day. These actions were, however, not used as a basis for the development of the pharmacology and toxicology of digitalis, but as arguments to show its stimulating power.

A Dr. Ferriar was puzzled by the fact that "whereas digitalis slows the heart (and seems, therefore, to be a sedative) it also stimulates the kidneys to increase the output of urine." In America the idea of its stimulating nature seems to have taken hold for its acceptance is explained by MacLean as "a circumstance not to be wondered at when it is considered how much the Brunonian philosophy has influenced medical theory and practice as well in that country." I dare say medical theory following Bruno would be more acceptable than a Baconian or Descartesian practice dependent on an initially mistaken axiom.

MacLean set out to prove that digitalis is one or the other, "because that any substance which proves sedative or stimulant at one time, in any given dose, or in any part of the body, must do the same at all times, in all doses, on every part of the body under similar circumstances." Any theory of medical practice which is founded on axioms not capable of proof is open to question, and perhaps the shade of Bruno smiled when MacLean wrote the foregoing conclusion. He showed his philosophy to be inconsistent when he said, "the thousands of frogs and other inoffensive animals that have been cruelly mangled and tortured, to establish the stimulant power of this substance, might have been saved." It is, however, of interest to examine his argument, which runs somewhat as follows:

Since digitalis retards the action of the heart, since it allays "certain painful irritations," since it produces extreme languor, faintness and weakness, since it lessens "vital warmth," nervous and muscular energy, and all without any signs of pre-

vious increased action or stimulation, it would seem to be unequivocally a sedative. He chose to ignore the excitement, vomiting and irritability which he himself described as resulting from the actions of digitalis. He described a case in which the pulse rate rose from 50 to 80 and then to 100 after the cessation of dosage with this drug, obviously an instance of cardiac irregularity released after the effects of digitalis wore off, but hardly to be interpreted as a loss of sedative action.

To the argument that digitalis stimulates the kidney he opposed an ingenious argument. According to MacLean's theory the kidney is not acted on directly by digitalis. His theory is correct in this supposition, but he could not admit that the effect is due, as Beddoes had said, to an increase in the momentum of the blood. He argued correctly that if digitalis acted on the kidney directly, one would expect and should have diuresis even in the absence of dropsy, but to explain this diuretic action without admitting a stimulation of the circulation he used an ingenious argument which could neither be proved nor disproved at the time. He ascribed to digitalis the power of reabsorption of fluid in the cavities of the body; "consequently it restores the impaired or lost function of the absorbents and places them in a condition of taking up and conveying to the blood fluids effused in cavities by no other than a direct sedative action."

He realized that to say digitalis increases the work which absorbents can do by a sedative action is rather incongruous and contradictory. So he explains further: "Digitalis seldom succeeds in men of great natural strength, of tense fibre, of warm skin, of florid complexion or of a tight, chordy pulse. On the contrary, if the pulse be feeble, or intermitting, the countenance pale, the lips be livid, the skin cold, the swollen belly soft and fluctuating, or the anasarca limb readily pitting under pressure, we may expect the diuretic effects to follow kindly." This statement, which is taken from Withering's essay, should have suggested to MacLean that digitalis is a stimulant because it worked so well on the weak and debilitated. He concluded that digitalis acts directly on the absorbent lymphatics opening into the cavities and argued that if these were irritated or stimulated, they would close and prevent loss of fluid. He maintained that these lymphatic vessels are actively absorbing vessels because they take up

more fluid when there is weakness and debility and when they are relaxed by digitalis.

His argument becomes involved and contradictory for he postulated a physiologic mechanism which works better when weak and debilitated and relaxed by digitalis. Why digitalis should relax these vessels only in ill health he did not explain, and it is obvious that his theory would fall flat if one were to question how edema is formed. He concluded his argument with specious rhetoric: "It seems consistent with the laws of human economy, that under an increased activity of the heart, the fluids should be determined to the surface, and under the opposite state of languor and debility, to the kidneys."

This type of reasoning and speculation may seem absurd and exaggerated in print, but it is not unusual even today. How many times does one hear that digitalis was given because it "might do some good." Such reasoning is as fallacious as that of the earlier day and more vicious, because, after all, MacLean may have reasoned poorly as to the nature of digitalis, yet he knew what effects it has and when it may be expected to work. The description of the actions of digitalis by MacLean is clear and essentially correct, even if he did not distinguish between action and toxicity. It might be pertinent to inquire if the physician of today knows as much of the actions of digitalis as he should? Does he always prescribe it correctly, in proper dosage and in the proper conditions? Does he understand its pharmacologic actions? Does he know its indications and contraindications? Does he know, when digitalis is being given, whether irregularities present are due to too much or too little of the drug? A review of the writings of Cushney or Sollman would surprise many a physician.

The use of digitalis in the treatment of other diseases was also described by MacLean. He considered its use in phthisis, in which condition it had been recommended by many, but he considered it of limited therapeutic value "even in the early stage." In influenza, especially the epidemic of 1802, it was employed with the "most beneficial results," particularly in those cases in

which cough and shortness of breath were annoying. In some cases "sixty to one hundred drops a day in combination with saline medicines, mild expectorants and free dilution" was used. "One of my medical friends of extensive practice," he related, "assured me he used some pints of the tincture in the epidemic." It would seem as if the oldsters in the influenza epidemic of 1802 had the benefit of a drug which was useful and had probably never before been administered in such cases. Its employment in pneumonia and pleurisy was, however, deprecated, and bleeding was considered the favorite remedy. In asthma, chronic catarrh and "dyspnea incident to persons advanced in life" it proved useful in relieving symptoms and also in "preventing remote evil, namely serous effusion." It was not as useful in the "spasmodic asthma and hooping cough."

The practitioners of Manchester extolled the virtue of the foxglove in acute rheumatism and in hemorrhage, but, said MacLean, "when a grain of the powder, with a half a grain of opium is given at bedtime, a few drops of laudanum with tincture of castor every four hours in menorrhagia, it is surely impossible and unreasonable to attribute the cure to this herb alone . . . nor is it more correct to ascribe to it relief obtained in rheumatic pains when an equal quantity of opium and probably calomel were taken at the same time." It was recognized even in this age of credulity and lack of experimental control that the uses of digitalis are limited. Even though physicians of the time did not understand its actions and toxic properties, it was used less indiscriminately than many drugs which have powers seemingly as extraordinary and unusual as this one. "Though few remedies will be found more extensively beneficial than the foxglove, yet few are so limited in their salutary effects, uncombined with others . . . Digitalis will scarce cure any disease without the aid of some other medicine, though it evacuate the water in dropsies." Digitalis is a great medicine. It is, however, a tricky servant. MacLean is to be remembered for pointing out its limitations.

## CAVERNOUS SINUS THROMBOSIS WITH RECOVERY

### REPORT OF A CASE

HENRY FULLER, M. D.  
LAKELAND

With the advent of the sulfonamides and of this group of drugs in combination with heparin in the treatment of cavernous sinus thrombosis, the diagnosis of this condition has not been rendered easier. Indeed, one important factor in the diagnosis heretofore has been death itself. Wechsler,<sup>1</sup> for example, stated that 'the outlook is quite hopeless.' Parson<sup>2</sup> observed that 'the patient always dies.' Eagleton<sup>3</sup> in 1926 reported but 3 recoveries out of 25 cases, and these were by surgical means. Grove<sup>4</sup> concluded that cavernous sinus thrombosis is practically always fatal. In contrast to these views are the reports of Schall,<sup>5</sup> Moore, Gardner, Bell and Tannenbaum,<sup>6</sup> Eshler and Blaisdell,<sup>7</sup> Lewis,<sup>8</sup> Morrison and Schindler,<sup>9</sup> Seydell,<sup>10</sup> Barnshaw,<sup>11</sup> Pace,<sup>12</sup> and Wolfe and Wolfe,<sup>13</sup> who recorded recoveries. Their cases illustrate the commonly accepted criteria for the diagnosis of cavernous sinus thrombosis.

There can be no doubt that treatment with the sulfonamides alone or in combination with heparin is often life-saving in this condition. The following case is reported as evidence of this contention.

From the Watson Clinic and Morrell Memorial Hospital, Lakeland.

### REPORT OF CASE

R. S., a 23 year old married Negro woman, entered the hospital Oct. 15, 1942, because of sore throat, fever and chills of eight days' duration. Examination showed a very ill woman. The temperature was 101 F., the pulse rate was 100, and the rate of respiration was 22. The right parotid gland was swollen and tender. The neck was stiff, and Kernig's sign was positive. Exophthalmos, edema of both lids, chemosis and a subconjunctival hemorrhage of the right eye were present. There was no pain on pressure on the eye, and the movements of the eye itself were normal. The pupillary reactions were normal. Fundal examination showed a flat disk and normal retinal vessels. The left eye was without abnormality except for a slight icteric tint to the sclera.

There was pronounced sordes of the buccal cavity, and on both tonsils and extending over part of the anterior pillars were whitish, elevated membranes. Smears and cultures from these showed diphtheria organisms. The remainder of the physical examination gave negative results.

The blood count was red blood cells 4,130,000 and white blood cells 18,400 with 97 per cent polymorphonuclear leukocytes and 3 per cent lymphocytes; the hemoglobin estimation was 78 per cent. The icterus index was 22. Urinalysis showed a bile-stained urine with a specific gravity of 1.020, which gave a 2 plus reaction for albumin; a few hyaline and granular casts were present in the sediment. Lumbar puncture revealed a bloody and yellow fluid (not a bloody tap) with an initial pressure of 340 mm. of spinal fluid and 8,960 red blood cells with 740 white blood cells. Culture of this fluid was negative. Kahn tests of the blood and spinal fluid gave negative results. The diagnosis was as follows:

- (1) Pharyngeal diphtheria.
- (2) Stomatitis and parotitis, right parotid gland.
- (3) Toxic hepatitis.
- (4) Right cavernous sinus thrombosis or right orbital cellulitis, or both.

Forty thousand units of diphtheria antitoxin was given intravenously, and 20,000 units was administered intramuscularly on admission. Sulfadiazine in doses of 1 Gm. every four hours day and night was commenced. Heparin was also begun immediately, but was given for only twenty-four hours when the available supply was

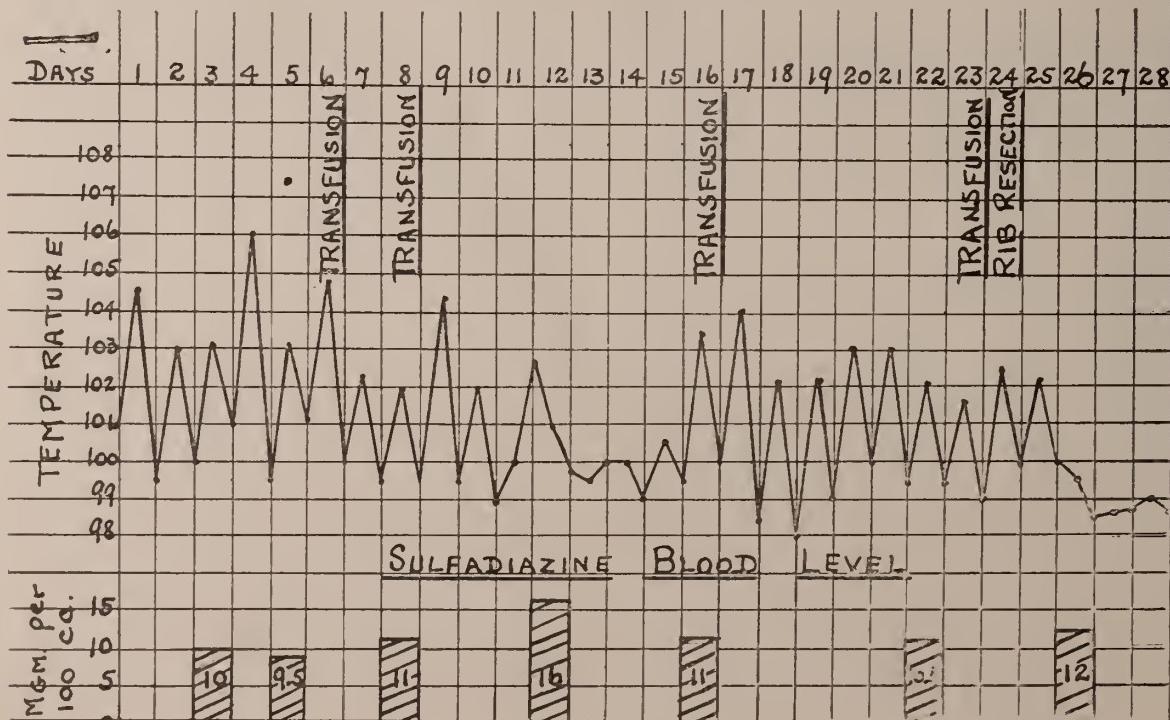


Fig. 1.—Clinical course during the first four weeks.

Date	Initial Pressure Mm. Spinal Fluid	White Cell Count	Per Cent Polys	Per Cent Mononuclears	Red Cell Count	Sugar, Mgm. per hundred cc.	Chlorides, Mgm. per hundred cc.	Protein, Mgm. per hundred cc.	Kahn	Culture	Appearance of Fluid
Oct. 16	340	740	91	9	8960	48	534	—	Neg.	Neg.	Bloody and Xanthochromic
Oct. 22	—	32	80	20	0	56	510	60	Neg.	Neg.	Xanthochromic
Nov. 5	170	6	30	70	—	—	—	—	—	—	Colorless, Clear
Dec. 23	90	1	0	100	—	—	—	—	—	—	Colorless, Clear

Fig. 2.—Summary of the Spinal Fluid Findings.

exhausted and no more could be obtained. The clotting time was satisfactorily prolonged while this was being given and was thirty-five minutes, eight minutes and nine minutes, respectively, when determinations were made.

The patient remained critically ill for some twenty-four days after admission. Within a few days the diphtheritic membranes disappeared, and the mouth, throat and right parotid gland became normal in appearance. The exophthalmos, edema of the lids and chemosis of the right eye did not recede apparently. Six days after admission a friction rub was noted low in the left axilla. Signs of consolidation appeared here, and fourteen days after admission thoracentesis revealed an empyema at this location. Following resection of a rib, a large amount of thick pus was drained. After this procedure the patient's condition became much better, and the temperature soon returned to normal.

The subsequent course was interesting and unusual. The exophthalmos abated somewhat, but did not disappear entirely. The patient continued to complain of exceedingly severe orbital and supraorbital pain on the right side, requiring frequent large doses of narcotics. About six weeks after the onset of the illness there was observed a paresis of all the extrinsic muscles of the right eye, and the pupil of that eye was dilated and did not react to light nor on accommodation. The cornea was anesthetic on this side. These findings may have been overlooked for some time. There was still no pain on

pressure on the eyeball. The spinal fluid was now normal.

Roentgen studies of the sinuses and the orbital bones gave negative evidence only. For relief of the pain roentgen treatment was begun on January 29. Seven treatments, totally 1,550 r, were given over the region of the right eye. After the third treatment, the patient was completely relieved of pain, and it is my impression that the exophthalmos has receded somewhat, although it is still present as is also a paresis of all the extrinsic muscles of the right eye. The patient now is well both subjectively and objectively except for the right eye.

#### SUMMARY

A case is reported fulfilling most of the criteria for cavernous sinus thrombosis.

1. There was a known site of infection in the tributaries of the cavernous sinus.
2. There were early signs of venous obstruction.
3. The nerves in the sinus were involved.
4. There was neighboring cellulitis of the soft parts.
5. There were symptoms of complicating disease.



Fig. 3.—Photograph shows the dilated right pupil.



Fig. 4.—Photograph shows the paresis of the right superior rectus.

6. There was meningitis, in this case, aseptic.

The only blood culture made was made after sulfadiazine therapy was commenced and was sterile.

The effect of roentgen therapy was dramatic in its relief of the orbital and supraorbital pain. The most likely explanation of this is that there remained some orbital cellulitis which was favorably influenced by the radiation.

Sulfadiazine was given almost continuously for three months. A very small amount of heparin was used. The patient recovered.

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#### ACUTE LEFT VENTRICULAR HEART FAILURE

##### REPORT OF A CASE IN WHICH ONE HUNDRED AND FORTY-SIX ATTACKS OCCURRED

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ORLANDO

The commonest of the functional diseases of the heart is congestive heart failure. It is due to myocardial insufficiency, and under the effects of strain of various kinds the myocardium may be unable to maintain a satisfactory circulation. Thus vascular stasis occurs in various parts of the body.

The myocardium often weakens long before signs of failure appear. At first the strain is for the most part unilateral. When left ventricular failure occurs, the right ventricle is soon affected. Failure of the right ventricle may be more responsible for symptoms and signs than left ventricular failure, which usually occurs first.

Dependent edema and ascites are the end stage of right ventricular failure. The principal evidence of advancing weakness of either ventricle is congestion behind that ventricle. In the case of left ventricular failure congestion occurs in the lungs; in case of failure of the right ventricle, it takes place in the veins of the liver. Failure of the left ventricle occurs as the primary manifestation of mild cardiac insufficiency at least three times more often than failure of the right ventricle.

Almost any kind of cardiac strain can eventually cause congestive heart failure. Certain factors are more important or common than others. Often several factors combine to precipitate failure in the same case. The commonest causes are valvular defects, both mitral and aortic, chronic hypertension, myocardial infarction and coronary thrombosis. Less common ones are rheumatic fever, thyroid disease, pulmonary disease, congenital defects, anemia and abnormally fast heart rate.

In a person with cardiac disease, failure is often precipitated by relatively trivial circumstances such as a slight cold, overeating or excitement. Seventy-five per cent of the persons with congestive heart failure are past the age of 50. It occurs, however, at all ages, even in childhood.

The case reported is of interest because of the relatively large number of attacks of acute cardiac failure which occurred in a seven month interval before death ensued.

REPORT OF CASE

Mr. M. B., a white man aged 61, with a left lower extremity amputated at a level just above the knee, was first seen on the occasion of an emergency night call on Feb. 10, 1941. At that time he was suffering from an acute attack of nocturnal dyspnea and pulmonary edema due to acute congestive failure. He was treated immediately with morphine, atropine and digifolin administered intravenously, and by the following morning was normal. At the end of the fifth day in bed he refused further rest and resumed his normal activities, which were those of a retired person.

Inquiry into his past history elicited the fact that he had suffered an acute coronary occlusion in 1940 and was kept in bed for six weeks. In addition, a syphilitic condition of long standing, treated sporadically and irregularly, and hypertension of at least fifteen years' duration were present.

On physical examination it was noted that the patient was short and moderately obese. His weight was 158 pounds. His complexion was florid, and his lips were mildly cyanosed. Psychologically, he had an unbalanced temper and was particularly irritable, extremely verbose and restless. The blood pressure was 180 systolic and 100 diastolic.

An electrocardiogram showed the typical signs of occlusion with severe myocardial damage. The fluoroscopic examination revealed a large aorta and left ventricular enlargement, conditions to be expected in a patient with hypertension of long standing and superimposed syphilis.

Following the first attack on February 10, after his return to normal activities the patient remained in normal health until the morning of April 7 when he again suffered from an attack of acute congestive heart failure. From that time on successive attacks of acute cardiac failure recurred. These attacks were all severe and necessitated immediate treatment. In the beginning all signs pointed to left ventricular failure only. After an indefinite number of attacks, however, failure of the right ventricle occurred with definite signs of dependent edema and enlargement of the liver.

During the first two months of the final illness attacks of failure were irregular, occurring at intervals of several days, and they were chiefly nocturnal in type. Thereafter they became more frequent, and a daily attack was experienced. In the last three weeks of the illness as many as 3 attacks of acute pulmonary edema occurred daily.

During the entire seven month period of the terminal illness, the patient underwent 146 attacks of acute left ventricular failure, characterized by pulmonary edema of great degree and its accompanying symptoms and physical signs.

The treatment consisted of bed rest, a restrictive diet, complete digitalization, occasional phlebotomy, and the administration of aminophylline, theobromine sodium acetate, ammonium chloride, mercupurin, sedatives and other routine drugs.

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PREPARATION OF SCIENTIFIC PAPERS

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The writing and publication of medical articles form an indispensable adjunct to the medical profession and a fundamental aid in its advancement. The well prepared paper is always acceptable if it is opportunely timed and presents a practical subject. Articles for the Journal should have general appeal for the majority of the members of the Association are general practitioners. The framework of a well planned paper consists of a descriptive title, appropriate subheads, a summary set forth at the beginning or the close, and cogent conclusions.

GENERAL DATA

*Kind of Material.*—New, scientific evidence is ever welcome, regardless of how much the subject to which it pertains may have been discussed. Not only does original experimental work form the basis for a good article but also the report of an interesting case, or the presentation of a clinical note or helpful suggestion. If the material has merit, the faults of a manuscript may be remedied. Its worth depends upon the presentation of (1) established, new facts, modes of practice or principles of value, (2) the results of suitable original research, or (3) a review of the facts relating to a given subject sufficiently comprehensive to permit the reader to derive therefrom legitimate, worth while conclusions.

*Title.*—A suitable title is both concise and inclusive. It should be short, but not too brief to be adequately descriptive. If an article is to serve a useful place in the literature on the subject, the title must identify it satisfactorily for indexing or cataloging. Ambiguity and wordiness are to be avoided. A subtitle often aids clarity, brevity and comprehensiveness. The title is of more importance than medical authors frequently realize. It should, therefore, be carefully chosen with a view to indicating clearly the contents and, above all, arresting the attention of the reader.

*Length.*—Some of the best and most illuminating articles are short. Nevertheless, a paper of a few hundred words may be long, and one of several thousand words may be short. The length, in other words, is relative. The question

to be determined is whether the material warrants the length. Often a manuscript is longer than necessary because of such common faults in construction as rambling, excessive and wearisome attention to trivial particulars, and verbosity. "Padding," whether it be a long review of the literature, an anatomic description taken from a textbook, or mere redundancy, should be avoided.

**Style.**—In scientific writing simple English terms are the most effective. A flowery style tends to distract the attention of the reader, as does also too liberal use of technical terms. Verbosity wastes space and makes reading tedious. The careful writer is often surprised to find how many words he can delete without changing the meaning of the idea expressed or the fact stated. The deletion of unnecessary words not only improves grammatical construction, but by facilitating direct, clear expression aids reading with understanding.

In the literature of a dignified science like medicine slang has no place. Discussions of serious matters are not properly couched in a tone of levity. Colloquialisms likewise are seldom in place. Personal allusions or reminiscences often enhance interest in an address before a medical society, and the author's personality and manner of presentation frequently cause a poorly organized and prepared paper to be acclaimed. In cold type, however, the personal references lose their effectiveness, and the faults of construction are glaringly apparent.

The finished writer makes several drafts of a paper before submitting it for publication. One learns to write acceptably by writing—and re-writing.

**Case Reports.**—The value of the case report in clinical medical literature is underestimated today. The brief, practical report of an interesting case presented with judgment and with the correct appreciation of relative values is welcomed by the reader and is always acceptable to the editor. It need not, and as a rule should not, be accompanied by an exhaustive review of the literature.

The technic of the case report calls for a clear, smooth, narrative style, not the jerky, telegraphic form of expression too often transcribed literally from original records hastily jotted down. All pertinent facts should be plainly stated in complete sentences. Abbreviations should be avoided. The hospital record number should be omitted. Negative results are only occasionally of value

and should not be cited except when they have bearing on the clinical history of the case. Elimination of negative and irrelevant material throws strikingly into relief the essential, salient features of the case described.

Clear presentation of the sequence of events is important. Also, the tenses should be used consistently. In giving the history of the case perhaps the simplest way to avoid confusion is to use the past tense throughout. If a pathologic or roentgen report is introduced, the tense should conform to that used in the history. In the summary of the paper the present tense should, however, be used.

If a brief review of the subject or an introductory statement of why the author considers it desirable to report the case precedes the report, the two should be clearly separated by a double space and the heading "Report of Case."

**Summary and Conclusions.**—A brief abstract of the article may appear at the beginning or the close. A short digest of a long article in the opening paragraph often serves as a stimulus to the reader. Some articles require no summary, but those of more than 1,500 words, those containing detailed description and those presenting a comprehensive survey of the literature on the particular subject practically demand a concise summary.

Deductions drawn from the material presented appear at the close and have particular value. Rigidly condensed, yet clearly reflecting the premises and deductions of the author, they catch the eye of editor, reader and abstracter alike. Frequently they gain in effectiveness by being numbered if they are more or less coordinate in structure and substance. In a summary combined with conclusions, however, care should be taken to number only the actual conclusions and not all of the items of the summary.

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Papers that have been published in other medical periodicals are not desired for publication in the Journal. They will, however, be abstracted if the author will send the Editor a reprint or the journal in which the article appears.

*Reference Books.*—The medical author will find "Medical Writing" by Morris Fishbein, M. D. (published in 1938 by the press of the American Medical Association, 535 North Dearborn Street, Chicago) and the books recommended therein of valuable assistance in the preparation of his articles.

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*Typing the Manuscript.*—Articles must be typewritten. Original copies only will be considered; carbon copies will not be accepted. The lines should be double-spaced. This spacing leaves room for editorial notations and instructions to the printer. The standard size of paper (8½ by 11 inches) is preferred. Only one side of the paper should be used, and a margin of an inch should be left at the sides. A word should not be divided at the end of a line. Paragraphs should be clearly indicated. The sheets should be fastened together with fasteners that can be easily removed.

*Footnote.*—If a paper has been read at a medical gathering prior to submission to the Journal, a footnote stating when and where it was read should be typed, in double space, on a separate sheet at the end of the manuscript. This sheet should be numbered with the pages of the text. An article is not rejected because it has not been read; however, a certain value is placed upon such presentation.

*Illustrations.*—When a paper is to be illustrated, the author is required to pay the cost of the cuts. The original drawings of charts and glossy prints of photographs should be submitted with the manuscript unless the author already has cuts suitable for use in the Journal. A special price schedule has been obtained from the engraver for members of the Association. When an author sends his check to cover the cost of the cuts, it goes direct to the engraver and is not entered in the Association's books. This service is given in the interest of the author and to insure uniformly good cuts for the Journal. Illustrations add to the value of most papers, and it is important that cuts be of high quality. When roentgenograms are reproduced, special enamel paper is used in the Journal so that no detail will be lost through imperfections in the paper.

Illustrations are eloquent if they illustrate. They should, however, be used with restraint and judgment. It is particularly desirable that they be of a size that can, with reasonable reduction, be accommodated to the type column of the Journal. Explanations, designated by letters on the illustration, should appear in the legend under the picture. On the back of each illustration the number of the picture and the name of the author should be given; also, the top should be indicated. If suitable labels for identification are not available, the information should be written lightly with a soft pencil. Pins and clips should not be used to fasten photographs, especially glossy prints. Illustrations should be sent flat and protected with cardboard. They should never be rolled or folded.

The author may indicate on the manuscript the place at which he would like to have each illustration inserted. The printer cannot, however, always follow these directions explicitly. Often it is feasible to group illustrations, thus saving expense. The individual sections should then be lettered instead of numbered. It is preferred that lettering be placed within the borders of the picture. Meticulous care should be given to the preparation of illustrations for they not only arrest the attention of the reader even before the title and the text, but they also constitute actual scientific evidence.

*Charts and Tables.*—All charts should be carefully prepared for exact reproduction. India ink on heavy white bond paper produces the best results. To facilitate reproduction with the least possible reduction, charts should be condensed

as much as possible. Usually, letters, numerals, asterisks or other indicating devices should appear on the face of the chart with their explanation in the legend.

Data should be tabulated only when this form is more vivid than presentation in the text. Tables, if carefully prepared and of suitable size, can be set up by the printer at no cost to the author. Since the size of the Journal page is 6 by 9 inches, large sheets containing many columns cannot be reproduced. Large tables at best attract few readers and they should, when possible, be revised to fit the space, or be broken up into sections. Unnecessary blank areas should be avoided for they waste paper and make for difficult reading. Several small charts or tabulations are of more value than one that is long, unwieldy and hard to follow. When it is essential to use a large sheet for a tabulation, it should be carefully prepared. A heavy grade of bond paper should be used; all figures and lines should be made with India ink; the figures should be large and plain. Such a table can be photographed and reduced, and a cut can be made to fit the printed page of the Journal. As with other illustrations, the cost of making the cut must be borne by the author.

Each table should be typewritten on a separate sheet of paper, with the author's name on the front or back. A uniform style should be followed in tables, they should be numbered consecutively, and each should have a descriptive heading. When necessary for purposes of condensation, standard abbreviations should be used; unusual abbreviations should be explained in a footnote to the table.

*Journalistic Usage.*—In order that a certain uniformity may obtain throughout the Journal, a number of general principles in regard to form have been adopted. Several are mentioned below:

1. When the author is a Doctor of Medicine, it is the policy of the Journal to include after the name the degree "M. D." only.
2. The responsibility for permission to quote published material and for the exactness of reproduction rests with the author.
3. Italics are used sparingly.
4. An effort is made to avoid the excessive use of nouns as adjectives qualifying other nouns.
5. Medical jargon is deleted or corrected. (Examples: "Acute abdomen" for "acute condition within the abdomen;" "flu" for "influenza;" "chronic appendix" for "chronic appendicitis;" and "surgical interference" for "surgical intervention.")
6. The use of abstract words in a concrete sense is banned. (Examples: "There is no pathology." "A malignancy was present.")
7. The use of an adjective to modify a word other than the one qualified is avoided. (Examples: "The right heart" for "the right side of the heart;" "the upper ab-

domen" for "the upper portion of the abdomen;" "the left lower lobe" for "the lower lobe of the left lung;" "the anterior pituitary" for "the anterior lobe of the pituitary gland;" and "upper respiratory infection" for "infection of the upper part of the respiratory tract."

8. To insure accuracy the author is expected to specify the unit used in stating the results of chemical determinations, such as "milligrams per hundred cubic centimeters" the first time the phrase appears and thereafter "milligrams," not "milligrams per cent."

9. Caution is advised in the use of such words as case, operate, dose and dosage, inject, temperature and fever, the former and the latter, the foregoing and the following, group, type, per cent and percentage, findings and found, developed, biopsy, bilious, eczema, strain, infection and inflammation, infection and infestation, rheumatism, asthma, and such superlatives as marked, quite, very and great.

10. Reference to paragraphs as "above" or "below" is avoided; "mentioned," "previously mentioned" or "aforementioned" may be used instead.

11. "Et cetera" or "etc." has no place in scientific papers as it is either meaningless or superfluous.

12. The use of "I" or "me," the first person singular, is adhered to as the most satisfactory usage when an author wishes to refer to himself. In reporting work done in conjunction with others, he may properly use "we," provided he makes clear who are represented by the "we." If he wishes to refer to one of two or more joint authors, the correct form is "one of us," and the initials or the name may follow in parenthesis if the authors so desire.

13. Figures are used for both whole numbers and fractions denoting numbers of cases or patients, also animals or specimens when considered analogously; values for measurement, including the amount of a dose, but the number of doses is spelled out; dates; clock time;

sums of money; numbers in tabular matter; and numbers indicating serial position.

14. Numbers are spelled out when they represent length of time; ordinal numbers; numbers used as nouns or in an indefinite sense; numbers of doses or injections; and all numbers except those of four digits in titles or subtitles of articles, subheadings, titles of abstracts and footnotes.

15. In general, the usage prescribed in "Medical Writing" by Fishbein for English and foreign words and phrases, spelling, capitalization, abbreviations, numbers, pharmaceutic products, and bibliographic material and abbreviations is adhered to by the Journal.

#### REPRINTS

A form letter, giving the price of reprints, is mailed to each author when the Journal which contains his article goes to press. Reprints must be ordered promptly inasmuch as the linotype is melted and reused by the printer sixty days after its use in the Journal. To obtain reprints after the linotype has been destroyed, it is necessary to reset the article, and the author must bear the additional expense. In order that essayists may secure reprints at a low, uniform price, the Association handles all details. Monies received from authors for reprints go direct to the printer, and the Association makes no charge for its services.

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OF THE

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APRIL 13 AND 14, 1944

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## ANNUAL CONVENTION—1944

The Seventy-First Annual Meeting of the Florida Medical Association is scheduled for April 13 and 14, 1944, at St. Petersburg. The first session will open at 1:30 p.m., Thursday; the last session at 12 noon, Friday. Thursday forenoon has been designated for meetings of specialty groups.

The meeting will be streamlined because of the war effort. Suggestions by our members on the scientific phase of the convention should be made directly to Dr. Herbert E. White, St. Augustine, chairman of the Committee on Scientific Work. There will be two meetings of the House of Delegates. Technical exhibits will be displayed as usual.

Officers of each specialty group are urged to notify the Association's secretary, Box 1018, Jacksonville 1, without delay, as to whether or not they plan to hold a meeting Thursday forenoon, April 13, 1944. This information is needed promptly for two reasons: (1) Owing to limited hotel facilities, arrangements for assembly rooms must be made early by your headquarters office. (2) Programs for group meetings should be completed by February 10 for publication in the Journal and the printed program.

Further information concerning the 1944 annual convention will appear from time to time in your Journal.

At its meeting last year, the House of Delegates left to the Board of Governors the designation of the date and place of the 1944 annual convention. The plans previously outlined were covered by action of the Board of Governors at a

meeting held in Jacksonville, October 31, 1943. Members present at that meeting were Drs. Robert D. Ferguson, chairman; Eugene G. Peek, president; Shaler Richardson, secretary; Louie Limbaugh; Leigh F. Robinson, and Walter C. Jones. Attending in an advisory capacity were Drs. John R. Boling, president-elect; Edward Jelks and Homer L. Pearson, delegates to the American Medical Association; George L. Cook, chairman, Committee on Child Health; W. C. Thomas, chairman, Committee on Maternal Welfare; J. C. Dickinson and Carol C. Webb, War Participation Committee, and Stewart Thompson, managing director.



## A STATEMENT OF GENERAL POLICIES

### BY A.M.A. COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

Pursuant to carrying out the duties imposed on it by the House of Delegates, the Council has adopted the following general policies:

1. The Council on Medical Service and Public Relations recognizes the desirability of widespread distribution of the benefits of medical science; it encourages evolution in the methods of administering medical care, subject to the basic principles necessary to the maintenance of scientific standards and the quality of the service rendered.

It is not in the public interest that the removal of economic barriers to medical science should be utilized as a subterfuge to overturn the whole order of medical practice. Removal of economic barriers should be an object in itself.

It is in the public interest that the standards of medical education be constantly raised, that medical research be constantly increased and that graduate and post-graduate medical education be energetically developed. Curative medicine, preventive medicine, public health medicine, research medicine, and medical education, all are indispensable factors in promoting the health, comfort and happiness of the nation.

2. The Council through its executive committee and secretary shall analyze proposed legislation affecting medical service. Its officers are instructed to provide advice to the various state medical organizations as well as to legislative committees concerning the effects of the proposed legislation. It shall likewise be the duty of its officers to offer constructive suggestions to bureaus and legislative committees on the subject of medical service.

3. The Council approves the principle of voluntary hospital insurance programs but disapproves the inclusion of medical services in those contracts for the reasons adopted by the House of Delegates at the 1943 meeting.

4. The Council approves voluntary prepayment medical service under the control of state and county medical societies in accordance with the principles adopted by the House of Delegates in 1938. The medical profession has always been very much opposed to compulsory health insurance because (1) it does not reach the unemployed class, (2) it results in a bureaucratic control of medicine, and interposes a third party between the physician and the patient, (3) it results in mass medicine which is neither art nor science, (4) it is inordinately expensive, and (5) regulations, red tape and interference render good medical care impossible. Propaganda to the contrary notwithstanding, organized medicine in general, and the American Medical Association

in particular have never opposed group medicine, pre-payment or non-payment, as such. The American Medical Association and the medical profession as a whole have opposed any scheme which on the face of it renders good medical care impossible. That group medicine has not been opposed as such is evidenced by the fact that there are many groups operating in the United States which have the approval of the medical profession, and members of these groups are and have been officials in the national and state medical organizations. That group medicine is the Utopia for the whole population, however, is not probable. It may be and possibly is the answer for certain communities and certain industrial groups if the medical groups are so organized and operated as to deliver good medical care.

5. The Council believes that many emergency measures now in force should cease following the end of hostilities.

6. The Council believes that the medical profession should attempt to establish the most cordial relationships possible with allied professions.

7. There is no official affiliation between the American Medical Association and the National Physicians Committee. However, since it is the purpose of the National Physicians Committee to enlighten the public concerning contributions which American medicine has made and is making in behalf of the individual and the nation as a whole, it is the opinion of the Council that the medical profession may well support the activities of the National Physicians Committee and other organizations of like aims.

8. American medicine and this Council owe a responsibility to our colleagues who are making personal sacrifices to answer the call of the armed forces. Therefore, the Council expresses the desire to cooperate with the medical committee on post-war planning in order to assist our colleagues in reestablishing themselves in the practice of medicine, and in the preservation of the American system of medicine.



## A. M. A. JOURNAL ANALYZES WAGNER-MURRAY-DINGELL BILL

DECLARERES IN EDITORIAL THE MEASURE PROPOSES  
A COMPLETE REVOLUTION OF THE PRACTICE  
OF MEDICINE IN THE UNITED STATES

"The Wagner-Murray-Dingell Bill proposes a complete revolution of medical practice in the United States," *The Journal of the American Medical Association* declared in an editorial in its October 16 issue. It continued:

Nearly every institution concerned in the prevention, diagnosis and treatment of disease would have to modify its methods of rendering service. The type of medical education and research and the administration of hospitals would be grossly altered. The immediate results of revolution are almost always destructive. For several years the institutions that protect and maintain the health of the American citizens would certainly be so disrupted as to make the efficient performance of their functions for the protection of the health of the American people almost impossible.

Is our situation today so desperate as to call for so radical a remedy? Medicine never hesitates to use radical measures when required in desperate situations. Do present conditions indicate defeat in the battle against death and disease? The reverse is true, according to reliable vital statistics. Never was the general death rate lower or falling more rapidly in relation to all the conditions that affect that rate than now. The infant death rate accepted throughout the world as the most accurate measure of public health, is lower in the

United States today than in almost any other country in the world. Although this decline has continued for many years and therefore might be expected to be approaching a minimum, it has shown an accelerated fall in recent years. Life expectation is greater here than in almost any other country and definitely longer than in any having systems of compulsory sickness insurance. The recent phenomenally rapid increase in the birth rate in recent years, which has always hitherto been accompanied by an increase in maternal infant death rates, has been accompanied by a decline in these rates in the United States.

The public health movement is certainly not declining in scope or efficiency. Public health departments, which almost invariably owe their origin and protection from the corrupting influence of politics to the activity of physicians either singly or in organizations, have now attained a momentum which is carrying their work into every community. The constant watchfulness of the medical profession has secured the administration of increasing numbers of these departments by competent trained personnel and strengthened their power to protect the public against disease.

The claim that American hospitals are in general best equipped of any in the world cannot be challenged. They are the models admired by other nations. Medical education, which at the beginning of the century was considered in many of its aspects disgraceful, has, thanks almost exclusively to the active supervision of the medical profession in the United States, attained world leadership.

These are not the conditions that call for revolutionary activity. Every phase of medical development in this country testifies to the soundness of the progress that has been made and indicates the desirability of continuing evolution.

The United States gained its leadership in medical education and care by methods that have been tested in the crucibles of time and economic hardship. Now it is proposed to abolish these institutions and methods and to substitute others whose trial in many countries has failed to produce health conditions equal to those existing here. The Wagner-Murray-Dingell Bill would abolish the volunteer control and inspiration that have brought medical education, hospital management, drug purity, research and medical service to their present eminence. As a substitute the people are offered a system controlled by salaried political bureaucrats. Scientists have too many aphorisms warning against such "ersatz" to participate in destroying what they have found good.



## NO NEED FOR REVOLUTION IN MEDICAL EDUCATION

"Is the rate of progress in medical education in America so slow and the stage which it has attained so inferior and the hope of further progress so hopeless as to call for a revolution?" *The Journal of the American Medical Association* for October 23 asked in the second of three editorials on the Wagner-Murray-Dingell Bill. The Journal continued:

Those who have observed this progress and present attainments, say emphatically "No." At the beginning of this century the American Medical Association first collected and published statistics on the medical school situation in this country. In 1904 it created a permanent Council on Medical Education and began a series of annual conferences. In 1909, at the time of the fifth annual conference, only 17 schools required two or more years of college work for admission. Many medical

schools were private enterprises depending on tuition for support. A large number made the payment of such tuition almost the only standards of admission, and often of graduation. In 1906 there were 162 medical colleges in the United States, many of them little more than "diploma mills."

The Council on Medical Education and Hospitals was without legal power; nor was it connected with any political or governmental agency. It achieved its results by advising and cooperating with medical schools, following thorough, impartial examination of curriculums, equipment, faculty and other requisites or essentials for teaching. Yet by 1943 the number of schools had been reduced to 76, whose standards of admission and whose quality of education were such as to place them among the foremost medical educational institutions in the world. This is still a larger number of medical schools than exists in any other two nations combined; they are graduating as many physicians as did the much larger number of inferior schools existing at the beginning of the century.

Medical education is the necessary ingredient for quality in medical practice. Only through improved medical education comes the possibility of better and better service to the public, carrying with it reduction in morbidity and mortality and extension of the life period.

There has been progress in medical education in other countries. In no other country, however, and certainly in none with compulsory sickness insurance, has the rate of advance been so rapid or the standards reached so high as in the United States. At the beginning of the century the superiority of European medical schools caused American physicians to flock to them to complete their education. Today the tide has been reversed. Physicians throughout the world seek American medical schools as the climax of their educational career. This period during which America outstripped the former world leaders in medical education was those years in which the physicians of the lagging nations were being forced into systems of compulsory sickness insurance.

Compulsory sickness insurance in Germany put "panel doctors" or "kassenaerzte" in a class apart from private practitioners. Even the advocates of sickness insurance will scarcely claim that the titles applied to insurance physicians carry any certification of professional superiority. In other countries insurance practitioners do not have the opportunities or inducements such as have led to extensive postgraduate work among general practitioners in America.

The Wagner-Murray-Dingell Bill in section 1111 proposes an entirely new method, revolutionary in almost every point, for the support and control of American medical education. The Surgeon General of the United States Public Health Service is to make "grants-in-aid" to such institutions as he thinks "show promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, hospital, disability, rehabilitation, and related benefits provided under this Act or to human knowledge with respect to the cause, prevention, mitigation, or methods of diagnosis and treatment of disease and disability." Will the Surgeon General, who-ever he may be, utilize the voluntary machinery set up by the medical profession and the medical schools to determine which institutions "show promise"? This bill would destroy the voluntary organization now so effectively performing this task.

Bureaucratic control of medical education will inevitably destroy the standards of excellence that now characterize the medical schools of America. Such a revolution in control could not well avoid disrupting the methods of selecting students which is essential to the preservation of the high personal qualifications and ethical integrity of the medical profession. Only a miracle could avoid temporary or permanent deterioration, if not complete destruction, of educational standards.

OFFICIAL WARNS DOCTORS TO BE ON  
GUARD AGAINST DRUG ADDICTS  
COMMISSIONER OF NARCOTICS SAYS PHYSICIANS  
ARE BEING IMPOSED ON WITH INCREASING  
FREQUENCY DUE TO DRUG SHORTAGE

Physicians should be warned to be on guard when strangers approach them regarding narcotic prescriptions, H. J. Anslinger, Commissioner of Narcotics, Washington, D. C., advised in a letter to the editor of *The Journal of the American Medical Association* and published in its October 30 issue. The letter follows:

*To the Editor:*—Because of the shortage of narcotic drugs in the illicit traffic, drug addicts are calling on members of the medical profession looking for a "soft touch." This is the addict's term for a doctor who will write a narcotic prescription after listening to a plausible tale. Hundreds of such cases are coming to our attention.

A drug addict goes into a doctor's office and simulates a bad cough. He tells the doctor that the only thing that will help him is a drug, the name of which he has on a slip of paper. He shows the doctor this slip of paper, on which the word Dilaudid is written. He takes a chance that the doctor is unaware of the fact that this drug is a derivative of morphine. It is surprising how many doctors follow the addict's suggestion and write a prescription for Dilaudid.

In another racket the physician is imposed on in a rather unusual manner and generally writes morphine prescriptions for quantities ranging from thirty to eighty  $\frac{1}{4}$  grain tablets. The addict calls on a physician and says his wife is in the care of a nurse and enroute by train to join him; that his wife is in a very serious physical condition, necessitating the use of morphine. He says the doctor has been highly recommended and that he wants him to take care of his wife on her arrival, place her in a hospital and perform an operation if necessary. The addict offers a retainer. He then alleges that his wife has just stopped off in a nearby city and is unable to proceed by train until a supply of morphine is obtained; that the nurse telephoned him that his wife's supply is exhausted. The physician writes a prescription for morphine, which the addict claims he will send to his wife by air mail. In some cases the doctor has been taken in by this story to the extent that he has retained a room in a hospital for a week until he realizes that he has been victimized.

When addicts find a notice of a doctor's death in an obituary column they sometimes call on the bereaved widow on the day following the death alleging that they are narcotic inspectors and have come to take charge of the doctor's morphine stock.

Pharmacists are being deluged with forged narcotic prescriptions. Blank pads are stolen from doctors' desks by addicts. Several times we have referred to numerous thefts of physicians' bags containing narcotics. A doctor's bag left in a parked automobile near a hospital is invariably stolen by a drug addict.

Physicians are being imposed on with increased frequency. I know they are extremely busy during this emergency. They should be warned to be on guard when a stranger tries to induce them to write a narcotic prescription. Many of the drug addicts today tell us that they are obtaining narcotics to satisfy their craving by going to various physicians and simulating some serious physical ailment.

H. J. ANSLINGER, Washington, D. C.  
Commissioner of Narcotics.



## MEMBERS IN ARMED SERVICES

Names and home addresses of members in the armed services, by county societies.  
Please report omissions or corrections to Box 1018, Jacksonville 1.

## ALACHUA

Andrews, Edwin H.....Gainesville  
Cobb, Alva T....."  
Collins, Grover C....."  
Dell, J. Maxey, Jr....."  
Jennings, Lloyd H.....Starke

## BAY

Adams, Daniel M.....Panama City  
Parker, Martle F....."  
Roberts, William C....."

## BREVARD

Cooke, Frank N.....Cocoa  
Hay, I. M.....Melbourne

## BROWARD

<sup>2</sup>Blount, Robert E. Ft. Lauderdale  
Camp, Milton N....."  
Carson, Russell B....."  
<sup>2</sup>Cohn, Jess V.....Hollywood  
Farringer, Robert H....."  
Lovejoy, M. Austin Ft. Lauderdale  
Lumpkin, Lloyd U....."  
Peavy, Henry J....."  
Pierce, Francis D....."  
Shell, Paul G....."  
Snyder, F. Leslie.....Hollywood  
Sory, Curtis H.....Ft. Lauderdale

## COLUMBIA

Busey, John F., Jr.....Lake City

## DADE

Adler, Lawrence.....Miami  
Agos, I. H.....Miami Beach  
Alexander, Julius.....Miami  
Alexander, Lassar....."  
Allen, Ralph F....."  
Arango, Roger J....."  
Auslander, Harold P. Miami Beach  
Baker, Juel M.....Miami  
Barge, William J....."  
Bernstein, William H. Miami Beach  
Bertram, Albert J.....Miami  
Boughton, Herman....."  
Burbacher, Charles R. Coral Gables  
Burch, John E.....Miami  
Capland, Lewis.....Miami Beach  
Carroll, Bruce D.....Miami  
Christian, William A. Miami Beach  
Clark, Irving T.....Miami  
Cleveland, Jack Q. Coral Gables  
Cogan, James R.....Miami Beach  
Coleman, Benjamin....."  
Coplan, Milton M.....Miami  
Cullipher, Edward W....."  
Dees, John....."  
<sup>2</sup>DeVore, Louise....."  
Dieterich, Frederick H....."  
Dix, John W.....Coral Gables  
Dowlen, L. Washington.....Miami  
Dowlen, Otto S.....Miami Beach  
Eichert, Herbert.....Miami  
Elam, James O....."  
Exley, David W.....Miami Beach  
Falk, Jack J....."  
Fishbein, I. Leo....."  
Fitzpatrick, Emmett T. ...."  
Forastiere, Roger J.....Miami  
Fox, Edward F....."  
Frehling, Stanley.....Miami  
Frobisher, H. B.....Coral Gables

Garrard, Hollis F.....Miami Beach  
Goodman, Bernard....."  
Gross, Alfred....."  
<sup>2</sup>Hanna, Fuad.....Miami  
Hardie, Dan, Jr....."  
Harris, Robert M....."  
Hewlett, Frank W.....Coral Gables  
Hinton, Andrew H.....Miami  
<sup>2</sup>Howdon, William M....."  
Howell, R. Spencer....."  
Hutson, Thomas W....."  
Jack, Ralph W....."  
Jenkins, Leslie M....."  
Kauders, Ferdinand H....."  
Kells, Paul....."  
Kline, Bernard.....Miami Beach  
Kuckku, Morris E.....Miami  
Kupper, William H....."  
Lamar, Carlos P....."  
Lawther, Harry C....."  
LeDrew, Frederick....."  
Leonard, George N. Miami Beach  
Levin, Alfred G.....Miami  
<sup>1</sup>Lister, George.....Miami Beach  
Letterer, A. Buist.....Miami  
McClamroch, James M....."  
McElheny, Franklin....."  
McKenzie, E. Norton....."  
McKenzie, Jack A....."  
McLemore, Carl S. Miami Beach  
McLeod, Norman W., Jr.....Miami  
Marion, Dominic A....."  
Martin, Marion C....."  
Maxwell, Eugene B. Miami Beach  
Meadow, Edward North Miami  
Messner, Paul O.....Miami Springs  
Milton, John D.....Miami  
Mitchell, George A....."  
Mosley, R. Sam....."  
<sup>2</sup>Mouradian, Albert H....."  
Nathan, David A.....Miami Beach  
Nuzum, Russell K.....Miami  
O'Donnell, William G....."  
Oliver, Robert M....."  
Otto, Thomas O. Miami Beach  
Owens, W. Duncan....."  
Payton, Frazier J....."  
<sup>1</sup>Pearce, N. O. ...."  
Pearson, Julius R....."  
Pearson, R. Judson, Jr. ...."  
Pepper, Max.....Miami  
Phillips, Kenneth....."  
Pollock, Benjamin G. Miami Beach  
Preston, Edwin P....."  
Putman, James H.....Miami  
Quillian, Warren W. Coral Gables  
Rand, Harold.....Miami  
Rash, Jack O. W....."  
Reckson, Murray M. Miami Beach  
Reese, Homer A.....Miami  
Richardson, John R. Miami Beach  
Robbins, Alexander....."  
Robbins, Bernard....."  
Roberts, Thomas L. Coral Gables  
Rogers, Hunter B.....Miami  
<sup>1</sup>Roth, Edward.....Miami Beach  
Salley, S. Marion.....Miami  
Sandberg, T. D.....Coral Gables  
Sappenstein, Ralph S.....Miami  
Saslaw, Milton S....."  
Scarborough, C. A....."  
Schwarz, M. Jandon Miami Beach  
Selevan, Sol....."  
Silverman, Harry Z....."  
Sisler, Bruce H.....Miami  
Skillling, Francis C....."  
Spicer, Robert T....."  
Stannus, Donald G....Miami Beach  
Sternberg, J. Charles.....Miami  
Stewart, Franz H....."  
Stewart, Joseph S....."  
Thomas, Efton J.....Miami Beach  
Torrado, Rene A....."  
Travers, M. Paul....."  
Turk, John P. ....Miami  
Vinson, Willie J....."  
Voris, Frank B....."  
<sup>1</sup>Walker, H. A. ....Miami Beach  
Wallace, Albert W....."  
<sup>2</sup>Walsh, Gerald J.....Miami  
Walterman, David....Miami Beach  
Weiland, Arthur H. Coral Gables  
Werblow, S. Charles .....Miami  
Whelchel, Lynn W....."  
Whitmer, Kenneth S....."  
<sup>\*</sup>Wigdor, Meyer ....Miami Beach  
Woods, Frank M.....Miami  
Youmans, Corren P....."  
Zimmerman, Paul A....."  
Zivitz, Nelson .....Miami Beach

DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

McSwain, Gordon H.....Arcadia  
Martin, Leldon W.....Sebring  
Simmons, S. J.....Belle Glade

## DUVAL

Adams, Thomas S. ....Jacksonville  
Baker, Archie J....."  
Baldwin, Donald M....."  
Ball, William H....."  
Bedell, Sullivan G....."  
Borland, James L....."  
Bowen, Frederick H....."  
Boyd, Charles W....."  
Canipelli, Edward....."  
Carithers, Hugh A....."  
Croft, George W....."  
Ferrara, John D....."  
Funkenstein, Dan H....."  
Galin, Jack....."  
Gorman, John M....."  
Graves, A. Judson....."  
Green, Daniel....."  
Hanson, Karl....."  
Hardgrave, George L....."  
Haverfield, W. Tracy....."  
Hurt, Floyd K....."  
Kemp, Simon I....."  
Kendrick, M. Hayne....."  
King, F. Gordon....."  
King, Raymond H....."  
Kirk, William W....."  
Leitner, Elmer E....."  
Lipscomb, T. H....."  
Lombardo, Samuel S. ...."  
Lovejoy, John F....."  
McCall, E. Frank....."  
McCullagh, William H....."  
Malone, Bert H....."  
Mangels, Martin, Jr. ...."  
Manning, William S....."  
"....."

\*Deceased. 1. U. S. Public Health Service. 2. Honorable Discharged.

MEMBERS IN ARMED SERVICES—Continued

Manson, A. Mackenzie Jacksonville

Mathers, Daniel H..... "

Mendoza, Carl C..... "

Milam, Ernest B..... "

Nelson, Thomas F..... Perry

Oberdorfer, Aaron Z..... Jacksonville

O'Dell, John C..... "

Oetjen, G. F..... "

<sup>1</sup>Osborne, Elton S..... "

Parks, Lorenzo L..... "

Patterson, James N..... "

<sup>1</sup>Pickett, W. H. Kansas City, Kans.

Porter, Harry W..... Jacksonville

Richards, Ferdinand .....

Rose, Joseph .....

Safer, Jacob V..... "

Simmons, Eugene D..... "

Slaughter, Frank G..... "

Sompayrac, Lauren M..... "

Stamps, Walker .....

Strumpf, Irving J..... "

Swift, Edwin C..... "

Thomas, R. Y. H..... "

Watt, E. Clements..... "

Wattles, F. Merrill .....

Weil, Nathan, Jr..... "

Weinreb, Joseph .....

Williams, Ashbel C..... "

ESCAMBIA

Anderson, E. V..... Pensacola

Bell, John D..... "

Click, Gustav N..... "

Essrig, Irving M..... Tampa

Hixon, William P..... Pensacola

Kennedy, S. G..... "

McSween, John C..... "

Mellen, Noel C..... "

Morse, George W..... "

Randall, William S..... "

Rubin, Nathan S..... "

Stebbins, Alvin L..... "

Tugwell, Wilton E..... "

Turboerville, Joe I..... Century

Williams, William L..... Pensacola

HILLSBOROUGH

Adamo, Frank S..... Tampa

Annis, Leonard S..... "

Blackmon, Heyward J..... "

Brown, Harold O..... "

Chunn, C. Frank..... "

Cole, Herschel G..... "

Costantino, Eugene F..... "

Cowart, James T..... "

Grable, James S..... "

Heath, Ralph T..... "

Helms, John S..... "

Hewit, Linus W..... "

Knowlton, Horace A..... "

Linz, Frank T..... "

Martin, Douglas D..... "

Mertz, R. Bradner .....

Murphy, David R..... "

Nix, Harold G..... "

Parsons, Hugh E..... "

Rudisill, C. A..... "

Ruskin, J. J..... "

Torretta, Joseph N..... "

Trice, William W..... "

LAKE

Ashton, W. Lee..... Umatilla

Bowen, Louis R..... Eustis

Bowie, Clyde F..... Leesburg

Gleason, Albert H..... Umatilla

McGuire, John F..... Clermont

Oetjen, Leroy H..... Leesburg

Wood, Will L..... Eustis

LEE

Allan, Harry L..... Ft. Myers

Clement, W. B..... Punta Gorda

Girardin, A. L., Jr..... Ft. Myers

Jennings, John L..... Boca Grande

Stead, Vergil G..... Naples

Stipe, Harvie J..... Ft. Myers

LEON-GADSDEN-LIBERTY-

WAKULLA-JEFFERSON

Andrews, Edson J..... Tallahassee

Clements, Merritt R..... "

Ekermeyer, Ernest W..... "

Holland, Francis T..... "

Johnson, A. B..... Jamestown, N.Y.

Miles, W. G..... Chattahoochee

O'Connor, James B..... "

MADISON-SUWANNEE

Black, Irby H..... Live Oak

Chappell, Frank V..... Madison

MANATEE

Floyd, Alva J..... Palmetto

Wentzel, W. E..... Bradenton

MARION

Cumming, Richard C..... Ocala

Harrell, Henry L..... "

Lytle, Carl S..... "

Moore, John P..... "

Russell, Ralph E..... "

ORANGE

Anderson, Claude ..... Orlando

Berry, Courtlandt D..... "

Bichard, Phillip M..... "

Butt, Thomas C..... "

Chappell, J. Rocher..... "

Christensen, Louis N..... "

Crisler, George R..... Winter Park

Economou, James G..... Orlando

Gwathmey, G. Tayloe .....

\*Hatfield, John R..... "

Henderson, Robert P..... "

Hitchcock, Edgar E..... "

Hoffmann, Carl D..... "

Ingram, Hollis C..... "

Irwin, Thomas M..... "

Jewett, Eugene L..... "

Kingsbury, Lawrence H..... "

Kundert, Palmer R..... "

Mathers, Fred .....

Mitchell, William S..... "

Orr, Louis M..... "

\*Osincup, Gilbert S..... "

Ramsey, Russell W..... Winter Park

Robertson, Don C..... Orlando

Scanlon, John J..... Winter Garden

Sears, Warren H..... Winter Park

Sessions, Raymond R..... Kissimmee

Stecher, Joseph L..... Orlando

Sutter, Leroy M..... "

Taylor, Byrne E..... "

Zieve, Sanford L..... "

PALM BEACH

Bippus, W. E..... West Palm Beach

Clarholm, Victor .....

Daly, Thomas E..... "

Dawson, G. M..... "

Derrick, C. J..... "

Gill, Richard S..... "

Herpel, F. K..... "

James, Lorenzo, Jr., Hayneville, Ala.

Kelley, Oscar L..... West Palm Beach

Nieder, James R..... Delray Beach

Ombres, S. Richard..... Palm Beach

\*Rotter, Saul D..... West Palm Beach

Smith, Michael .....

Sory, Bailey B..... Palm Beach

Sory, James R..... West Palm Beach

Stanley, Thomas Z..... "

Weems, William H..... "

Wilkins, William B..... Palm Beach

PASCO-HERNANDO-CITRUS

Manley, David B..... Zephyrhills

PINELLAS

Anderson, C. O..... St. Petersburg

Farber, William P..... "

Farrington, C. L..... "

Feaster, Orion O..... "

Frederick, A. R..... "

Funk, Neil E..... "

Gable, Linwood M..... "

Gable, N. W., Jr..... "

Grace, Angus D..... "

Groves, W. H..... Clearwater

Hagan, V. LeRoy .....

Hagood, John D..... "

Harden, W. W..... St. Petersburg

Harrison, Everett M..... Dunedin

Hebard, Charles E..... St. Petersburg

Langley, Francis H..... "

McConnell, W. H..... "

Marr, Norval M..... "

Meyer, Francis P..... "

Morin, H. Gerald .....

Murphy, Dan'l F. H..... "

Needles, Robert J..... "

Owen, R. Wynn S..... "

Purcell, Thomas R..... Tarpon Springs

Rogers, H. Milton .....

Rowell, John P..... "

Rudolph, Councill C..... "

Ulm, A. Hardy .....

Whaley, F. Eugene .....

Wood, Rowland E..... "

Woodville, John B..... "

Wright, Claude B..... "

Wylie, LeRoy A..... "

POLK

Annis, Jere W..... Lakeland

Barranco, Anthony J..... Lake Wales

Bond, Benjamin J..... Winter Haven

Bosworth, Joe M..... Lakeland

Clark, Samuel J..... "

Dykes, Chapman .....

Gachet, Fred S..... Lakeland

Hargrove, Julian L..... Bartow

Keramidas, T. C..... Winter Haven

Kibler, John M..... Lakeland

Lancaster, L. L..... Bartow

Martin, Emmett E..... Haines City

Ralston, Raymond H..... Lakeland

Tomlinson, J. Pitt, Jr., Lake Wales

PUTNAM

Bell, F. Emory .....

Palatka

Gurganious, Allen P..... "

ST. JOHNS

Britt, Reddin .....

St. Augustine

Norris, Hardgrove S..... "

Spencer, John .....

"

Webb, Walter D..... "

## MEMBERS IN ARMED SERVICES—Continued

ST. LUCIE-OKEECHOBEE-	SARASOTA	VOLUSIA
INDIAN RIVER-MARTIN		
Davey, Walter F..... Stuart	Butcher, John M..... Sarasota	Drohomer, P. A..... Daytona Beach
Goodwin, Hugh B., Jr. Ft. Pierce	Hoskins, W. H..... Venice	Jennings, William L. " "
Hardee, E. B..... Vero Beach	Martin, Stanley T..... Sarasota	Jones, C. B..... New Smyrna Beach
Martin, Leon H..... Ft. Pierce	Matthews, A. Lamar..... "	Lenholt, Eric H..... Daytona Beach
Robertson, James C. Vero Beach	Miller, Cecil E..... "	Myres, M. J..... " "
Stoner, Cyrus H..... Ft. Pierce	Patton, Sherrel D..... "	Reeser, Richard, Jr. " "
	"Powers, Earl J..... New York	Rutter, Joseph H..... " "
	White, Millard B..... Sarasota	Seltzer, Morris B..... " "
		Silsby, Harry Z. New Smyrna Beach
		Tribble, Charles E..... DeLand
		Vallotton, J. Ralph Daytona Beach
*Deceased.		Wells, J. Ralston " "
<sup>1</sup> U. S. Public Health Service.		West, J. Richard " "
<sup>2</sup> Honorably Discharged.		Whitney, Karl R..... " "

\*Deceased.

<sup>1</sup>U. S. Public Health Service.

<sup>2</sup>Honorably Discharged.

## BIRTHS, MARRIAGES AND DEATHS

## BIRTHS

Dr. and Mrs. A. Scott Turk of Quincy announce the birth of a daughter, Elizabeth Edy, on May 19.

Dr. and Mrs. Ralph N. Greene, Jr., of Coral Gables announce the birth of a son on October 10.

## MARRIAGES

Dr. George M. Zeagler of Palatka and Miss Doris Strickland of Jacksonville were married on October 1.

Dr. H. Quillian Jones and Mrs. Marie Burris of Fort Myers were married on October 13.

## DEATHS

Dr. H. Frank Davis of Miami died on October 17.

Dr. James R. McEachern of Tampa died on November 1.

Dr. James D. Pasco of Jacksonville died on November 12.

## STATE NEWS ITEMS

In October a special committee was appointed to represent the Florida Medical Association, when called upon by the Florida Industrial Commission (Workmen's Compensation Division), in matters relating to a fee schedule. Those appointed on this special committee were Dr. Ferdinand A. Vogt, Miami, Chairman; Dr. A. M. Bidwell, Tampa; Dr. F. L. Fort, Jacksonville; Dr. Lloyd J. Netto, West Palm Beach; Dr. Eugene G. Peek, Ocala, and Dr. W. McL. Shaw Jacksonville.

The first meeting of this special committee was held in Jacksonville, October 31, at the request of Mr. Walter E. Rountree, Director, Workmen's Compensation Division of the Florida Industrial Commission. In addition to the doctors, representatives from carriers and from employers attended.

Stewart Thompson, Jacksonville, attended the annual conference of secretaries of state medical associations in Chicago, November 19 and 20. The trip was made at no expense to the Florida Medical Association.

Information has been received that Dr. George A. Munch, formerly of Tampa, died August 12, 1943, in Springfield, Ohio. Dr. Munch was convicted twice and sentenced to serve two five-year terms in the federal penitentiary for selling bogus medical licenses through the mail.

Graduation exercises were held at the School of Aviation Medicine, Randolph Field, Texas, on August 26 following completion of the course for aviation medical examiners. The didactic portion of the course was conducted at the School of Aviation Medicine, Randolph Field, Texas, and the practical portion of the course at the three army air forces classification centers. The list of Florida doctors graduating follows:

Anthony J. Barranco, 1st Lieut., Lake Wales.  
Carl C. Mendoza, 1st Lieut., Jacksonville.  
Robert J. Needles, Major, St. Petersburg.  
Murray M. Reckson, 1st Lieut., Miami.  
Francis C. Skilling, Major, Miami.  
Frank L. Snyder, Captain, Hollywood.  
Cyrus H. Stoner, Major, Fort Pierce.

Dr. Charles L. Clay of Miami, superintendent of the Jackson Memorial Hospital, resigned, effective November 1. It was announced that the hospital would be reorganized into two divisions with a medical director and a business administrator.

The 1944 annual session of the American Medical Association will be held in Chicago, June 12 to 16. The meeting was previously scheduled for St. Louis. The change was necessary because of information received that it would not be possible for St. Louis to provide adequate hotel accommodations.

Dr. Frederick K. Herpel of West Palm Beach, Dr. Royal H. Mayhew of Fort Lauderdale and Dr. R. O. Cooley of West Palm Beach were guest speakers at the local Rotary Club's luncheon meeting in October. Dr. Herpel, a past president of the club, is at present a lieutenant colonel in the Army Medical Corps, and the members expressed pleasure at his presence.

Dr. Arthur J. Bieker of St. Petersburg, addressed the Lions Club of Clearwater in October.

Dr. Orville L. Barks, formerly of Sanford, is reported a prisoner of war at Oflag 64, Germany. He was captured in Tunisia in February. Dr. Barks is a first lieutenant in the U. S. Army. He received his commission in the Reserves and was called to active duty in 1940 and again in 1942. Lieutenant Barks was graduated from Washington University in 1938. This information was received in a communication dated November 8, 1943, from Mrs. O. L. Barks who now resides in Columbus, Ga.

The total attendance at the annual meeting of the American Academy of Ophthalmology and Otolaryngology, held in Chicago, October 10-13, was 1961. Members of the Florida Medical Association who attended this meeting were: Drs. A. B. Connor, Ft. Lauderdale; Charles W. Boyd, Raymond H. King, W. Jerome Knauer, Shaler Richardson, H. Marshall Taylor, Jacksonville; Nelson M. Black, Andrew G. Brown, Miami; Francis E. Denman, Walter T. Hotchkiss, Louis G. Lytton, Miami Beach; Charles J. Heinberg, M. A. Lischkoff, Pensacola; Charles C. Grace, St. Augustine; Sherman B. Forbes, Blackburn W. Lowry, Joseph W. Taylor, Tampa; William Y. Sayad, West Palm Beach.

Dr. M. A. Nickle of Clearwater was the guest speaker at the local Rotary Club's luncheon, October 27. He discussed the Wagner-Murray-Dingell Senate Bill.

The following doctors from Florida attended the meeting of the Aero Medical Association of the United States, at Cincinnati, October 26-27, 1943: Howard K. Edwards, Miami; Ralph N. Greene, Jr., Coral Gables; Matthias P. Meehan, William Parson, Miami; John H. Thomas, Gainesville.

Dr. W. C. McConnell of St. Petersburg was on the program to read a paper on "Neuropsychiatric Aspects of Civilian Pilot Examinations." He was unable to attend the meeting and his paper was read by a member of the program committee.

Dr. Charles W. Pease of Tampa was appointed in November as acting director of the consolidated city-county health department to succeed the late Dr. J. R. McEachern.

#### EDMUND PENDLETON SHELBY

Dr. E. P. Shelby of Venice died in Lexington, Kentucky, on September 24, after an illness of several months. He had been staff consultant at the Florida Medical Center for more than twelve years when the Army took over the hospital. During this time he had interested himself in civic affairs both of Venice and Sarasota, where he maintained an office. He was a member of the board of directors of the Venice-Nokomis Chamber of Commerce.

Dr. Shelby, born in 1866, was descended from one of the oldest families in Kentucky, his great grandfather, Isaac Shelby, being its first governor. He received his medical training at the New York University Medical College from which he was graduated in 1891. He practiced for many years in New York, where he became recognized as a diagnostician of outstanding ability. He received his license to practice in Florida in 1925.

Dr. Shelby was a member of the Sarasota County Medical Society, the Florida Medical Association, the American Medical Association, and the American College of Physicians.

**ROBERT GREEN NOBLES**

Dr. Robert G. Nobles of Pensacola died September 23, after a long illness, at the age of 45.

Dr. Nobles received his medical degree from Emory University in 1921, and his Florida license the same year. Settling in Pensacola, he limited his practice to the treatment of diseases of the eye, ear, nose and throat, and soon built up an extensive practice. He lent his professional skill to the Lions Club in their program to supply glasses for those with impaired vision. For many years he was port physician at Pensacola.

Immediate survivors are his wife, a son and one daughter; his father and three sisters.

Dr. Nobles was a member of the Escambia County Medical Society, the Florida Medical Association, and the American Medical Association.

**HARTLEY FRANKLIN DAVIS**

Dr. Frank Davis of Miami died on October 16. He was 44 years of age.

After serving in World War I, Dr. Davis completed his education at the St. Louis University School of Medicine, from which he was graduated in 1924. He came to Miami the following year, where he practiced until last year when he entered Military Service as a lieutenant. He was stationed at Ft. Bragg for thirteen months, but was discharged recently owing to ill health.

He was a member of the Dade County Medical Society, the Florida Medical Association, and the American Medical Association, the 40 and 8 Society of the American Legion, and Pi Kappa Alpha and Phi Beta Pi fraternities. He leaves his widow, Mrs. Aurora Davis; a son, James; two daughters, Marilou and Connie; two brothers and a sister.

**CHARLES LEITNER JENNINGS**

Dr. Charles L. Jennings, prominent physician and surgeon of Jacksonville for many years, died on September 30 at Winnsboro, S. C., at the age of 62. He was an honorary member of the Duval County Medical Society and the Florida Medical Association.

Dr. Jennings was graduated from the University of Maryland School of Medicine and College of Physicians and Surgeons in 1906, and obtained his Florida license the following year. He practiced in Jacksonville, and at the time of his retirement was chief of the department of surgery at St. Luke's Hospital.

He is survived by four daughters, Mrs. DuBose Rivers and Misses Leonora Dean Jennings, Joy Norris Jennings and Nancy Marian Jennings, Winnsboro; two sons, Charles L. Jennings, Jr., and James Marvin Jennings, also of Winnsboro.

**COMPONENT COUNTY SOCIETIES****DADE**

The Dade County Medical Society held a clinical and pathologic conference at the Jackson Memorial Hospital on the evening of November 2, led by Dr. Philipp Rezek.

**DUVAL**

The Duval County Medical Society met at St. Luke's Hospital, Jacksonville, on the evening of November 2. The main feature of the program was the presentation of a technicolor-sound motion picture on "Sex Hormones; Physiology, Diagnosis and Therapy."

**MARION**

The Marion County Medical Society held its regular luncheon meeting at the Harrington Hotel, Ocala, on October 21. Two of the members, recently returned from a week's attendance at operations, clinics and lectures in New Orleans, gave highlights of their observations and experiences, which called forth a lively discussion of some of the newer methods and advances in surgical technic. Dr. Tom Wallis was welcomed back after a year's absence.

#### PINELLAS

At the annual meeting of the Pinellas County Medical Society held October 1, Dr. John A. Hardenbergh was installed as president. Officers elected were: president-elect, Dr. Arthur J. Bieker; secretary-treasurer, Dr. W. C. McConnell. The following delegates and alternates were chosen to represent the society at the next annual meeting of the State Association: delegates—Drs. J. A. Hardenbergh, W. C. McConnell, R. H. Knowlton, A. M. Feaster, J. A. Herring; alternates—Drs. A. S. Anderson, M. O. McNay, A. J. Wood, J. A. Bradley, A. L. Mills.

#### POLK

At the monthly meeting of the Polk County Medical Society held at Haven Hotel in Winter Haven on October 18, enthusiastic approval was given to the suggestion made by Dr. Lawrence M. Zell, acting director of the Polk County Health Department, that Polk County provide adequate isolation facilities for persons with far advanced tuberculosis. It was estimated that Polk County would need a minimum of fifty beds in addition to the facilities provided by the Tuberculosis Sanatorium at Orlando.

#### VOLUSIA

The members of the Volusia County Medical Society held their first meeting of the season on Thursday evening, October 14, at the Bath and Tennis Club, Daytona Beach. After dinner, a scientific meeting was held at the Volusia County Health Unit.

#### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

**THE COMPLEAT PEDIATRICIAN.** By Wilbert C. Davison, M. A., D. Sc., M. D., Professor of Pediatrics, Duke University School of Medicine, Durham, N. C. The Compleat Pediatrician with its emphasis on symptoms and signs as clues, rather than on description, was compiled in the hope that it would be of value from a practical point of view. Physicians, when confronted with a child who has certain symptoms, cannot always obtain the necessary help in diagnosis from a systematic textbook, for often they are unable to interpret the patient's disease from his signs, and consequently cannot locate the description of the correct disease. Cloth. Price, \$3.75. Durham, N. C.: Duke University Press, 1943.

**STRABISMUS; ITS ETIOLOGY AND TREATMENT.** By Oscar Wilkinson, A. M., M. D., D. Sc., F. A. C. S., former Surgeon in Chief of Washington Eye and Ear Hospital, in collaboration with Richard W. Wilkinson, M. D., M. Sc., F. A. C. S., instructor in ophthalmology, George Washington University Medical School, Washington, D. C. Dedicated to the cross-eyed child with the hope it

may receive earlier and more efficient treatment. Cloth. Price, \$4.00. Pp. 369, with illustrations. Boston: Meador Publishing Company, 1943.

**THE NATURE AND TREATMENT OF MENTAL DISORDERS.** By Dom Thomas Verner Moore, O. S. B., Ph. D., M. D., Professor of Psychology and Psychiatry, Catholic University of America. Foreword by Edward A. Strecker, M. D., Professor of Psychiatry, Graduate School of Medicine, University of Pennsylvania, Philadelphia. The book is marked with the direct simplicity and concreteness of applied knowledge. It offers a rare combination of scientific objectivity of attitude in psychiatry and skilled humane insight into the individual workings of living personality. Constructive contributions of diversified trends of thought in empirical psychiatry are surveyed. As exemplified with rich suggestion in step by step case descriptions of their application in the solution of actual problems of life, the author points the way to what might be called an eclectic therapy. Flexible adaptation of technic to the needs of the daily life situation of the actual person is the key principle. As physician, teacher, and counselor, Dr. Moore encompasses in the therapeutic problem not only the physical and psychic bases of mental disturbances, but also the social, economic and moral pressures in the patient's conflict. Cloth. Price, \$4.00. Pp. 316. New York: Grune & Stratton, 1943.

#### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville 1, for abstracting in this department.*

**SOME OBSERVATIONS ON THE USE OF NICOTINIC ACID AMIDE AS AN ADJUNCT IN OBSTETRIC ANALGESIA. A PRELIMINARY REPORT,** PERDUE, J. RANDOLPH, SOUTH. M. J. 36:198-201 (March) 1943.

The results obtained by adding nicotinic acid amide to the barbiturate-hyoscine method of analgesia in 159 consecutive obstetric cases are summarized in a preliminary report.

The role of nicotinamide in the proper utilization of oxygen in the individual cell is discussed, and a physiologic basis for its use in obstetrics is presented. The relationship, biologic as well as chemical, between "coramine" and nicotinamide is noted.

Although the physiology, metabolism and excretion of nicotinamide are little known, it is established that the toxicity is very low. While the amount needed by the parturient woman and her offspring is not fully determined, nevertheless it is concluded that large doses during labor have no disadvantages and may be of appreciable value.

In the series of cases analyzed, the use of this adjunct in obstetric analgesia resulted in less maternal restlessness, and considerably fewer babies required resuscitation.

CHONDRODYSTROPHIA CALCIFICANS CONGENITA, RAAP, GERARD, MIAMI, AM. J. ROENTGENOL. 49: 77-82 (Jan.) 1943.

Over a period of four years, a study of chondrodystrophia calcificans congenita in four children of the same family was made, which proved a familial and congenital characteristic.

Roentgen examination of the long bones of 10 month old male twins, one living and one deceased, indicated flaring of the distal ends of the ulnas and tibias; also, the mottled granular appearance in the ankles, wrists and other joints, in contour like that of the bony structures in normal ossification, presented angular densifications rather than rounded densities. Microscopically, postmortem examination confirmed this evidence of calcification.

Like changes were demonstrated roentgenologically in the ankles and wrists of a brother, aged 10 days, establishing the presence of these changes at birth. The persistence of the calcific deposits was illustrated in roentgen studies of the sister, aged 2½ years, and their disappearance was demonstrated in further studies when she was 4 years old.

The previous reports of disturbances of similar nature, all, however, with extenuating factors, are reviewed. In the cases presented the children were apparently normal in every other respect.

The conclusion appears warranted that the abnormal calcifications described are pronounced at birth and disappear at the approximate age of 3 years.

**THE ROLE OF THE GRAM POSITIVE DYPLOCOCCUS AND OTHER PATHOGENS IN THE STAGNANT COLON, SMITH, MARVIN, MIAMI, REC. GASTROENTEROL. 9: 411-422 (Nov.-DEC.) 1942.**

One thousand sixteen cases of infection in stagnant colons are reported. Persistent constipation, headaches, dizziness, nausea, vomiting, anorexia, flatulence and mental depression are given as the chief complaints. Physical examination usually reveals flabby abdominal muscles, tympanism and a firm fecal mass in the cecum; the descending colon is usually sensitive to palpation. Rectal and sigmoid examinations generally

disclose a redundancy of the mucous membrane. Blood studies and urinalysis are negative. Roentgen examination usually reveals stasis throughout the colon, also absence of haustral markings in certain areas. The diagnosis of the stagnant colon is based on microscopic and culture studies of the feces. Gram positive diplococci and organisms producing hydrogen sulfide will be found in a great majority of the cases.

The administration of washed oxygen into the colon clears out the hydrogen sulfide producing organisms. Enemas containing gentian violet, the autogenous vaccines reduce the gram positive diplococcus infection and relieve the symptoms. Sulfa and silver preparations have not been found satisfactory in these infections.



**WHAT OBLIGATIONS DO WE HAVE TO THE RADILOGIST WHO IS CALLED INTO THE NATIONAL SERVICE? DICKINSON, J. C., TAMPA, RADIOLOGY 38: 584-586 (May) 1942.**

An able discussion is presented of the three-fold obligation of the roentgenologist in private practice to his colleague called into military service, namely, to see that he goes at the least possible sacrifice, to keep his practice intact in so far as possible, and to make sure that his temporary withdrawal results in no financial profit to his associates who remain at home. The nature of the specialty of roentgenology and the problems peculiar to the physician who practices it are set forth as reasons why cooperative endeavor can effect a realization of these objectives more readily than in other branches of medicine.

A workable plan is advocated, which is in successful operation in a number of communities. By this plan it is possible to keep the office open, maintain intact the trained personnel and operate the office at a profit for the absent roentgenologist pending his return.

If his fellow roentgenologists are willing to expend the necessary effort and time and the physicians who were accustomed to refer their work to him will cooperate by continuing to do so, the practice of the roentgenologist in military service may in most instances, the author believes, be carried on satisfactorily and profitably for him by his colleagues.



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## ADVERTISERS' NOTES

## THE SCHOOL-CHILD'S BREAKFAST

Many a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, small wonder that he is listless, nervous, or stupid at school. A happy solution to the problem is Pablum. Pablum furnishes protective factors especially needed by the school child—especially calcium, iron and the vitamin B complex. The ease with which Pablum can be prepared enlists the mother's cooperation in serving a nutritious breakfast. This palatable cereal requires no further cooking and can be prepared simply by adding milk or water of any desired temperature. Mead Johnson & Company, Evansville, Ind., U. S. A.



## NEW ALUMINUM HYDROXIDE GEL PREPARATION

The value of orally administered aluminum hydroxide gel in promoting healing, relieving pain and controlling pain of gastric and duodenal ulcer, and in controlling gastric hyperacidity, is now well recognized. Various preparations have been available. Many of these show obvious variations in consistency, color and palatability. Submitted to laboratory tests they also show differences in specific gravity, acid combining power, hydrogen ion concentration and carbon dioxide content. Most of these preparations are marketed under proprietary names and some are admixed with other antacids or vegetable gums.

The inclusion of aluminum hydroxide gel in New and Nonofficial Remedies and its admission to U. S. P. XII prompted the Squibb Laboratories to offer the preparation under the official name and, of course, in conformity with official specifications and standards.

As offered by E. R. Squibb & Sons, Aluminum Hydroxide Gel is pharmaceutically an elegant preparation of a fluid consistency. The suspension is practically snow white, pleasant to take, lacking any suggestion of astringent taste. Diluted with two or three parts of water the Gel may be administered by gastric drip, or taken in 1 or 2 teaspoonful doses in water or milk. Aluminum Hydroxide Gel Squibb is available in 12-ounce bottles.



## ANOTHER WYETH MEMORIAL TO MEDICINE

Pharmacy's role in World War II and its success in making America independent of foreign sources for supplies of vital drugs, such as digitalis, modern medicine's most commonly used heart stimulant, were keynote topics at unveiling ceremonies for the fifth painting in the famed "Pioneers of American Medicine" series in Philadelphia, Nov. 5, during National Pharmacy Week.

A distinguished audience of 250 pharmacists, physicians and scientists gathered from all parts of the United States to pay tribute to William Proctor, Jr., world-famous for his work in the standardization of drugs.

The 1943 painting is entitled "The Father of American Pharmacy" and depicts Proctor (1817-1872), studying a formula for the standardization of drugs while at work with an assistant in his laboratory.

The principal speaker at the unveiling, held at a dinner in the Barclay, was Dr. Ivor Griffith, Ph. M., Sc. D., F. R. S. A., president of the American Pharmaceutical Association and president of the Philadelphia College of Pharmacy and Science. A special exhibit of drug producing plants, formerly imported, now cultivated in the United States, was shown at the unveiling.

Back in 1917, while a Navy medical corps pharmacist at Brest, France, Frank F. Law, president of John Wyeth & Brother, Inc., conceived the plan of creating an enduring monument in oils to American medical pioneers

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**MEDICINE**—Courses to be announced in January.

**GYNÉCOLOGY**—Two Weeks Intensive Course starting February 7th. Clinical Course.

**OBSTETRICS**—Two Weeks Intensive Course starting February 21st.

**ANESTHESIA**—One Week Course in Continuous Caudal Anesthesia for Obstetrics.

**OPHTHALMOLOGY**—Clinical Course.

**OTOLARYNGOLOGY**—Special and Clinical Courses.

**ROENTGENOLOGY**—Courses in X-Ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

**UROLOGY**—Two Weeks Course and One Month Course available every two weeks.

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when he witnessed the marvels of American surgery among battle wounded. Law determined then that, if he ever got the opportunity, he would erect such a monument. His dream came true five years ago when, at his behest, the Wyeth company commissioned Cornwell to begin the series.

Other paintings in the series, which are loaned to medical schools and medical societies, are "The Dawn of Abdominal Surgery," a tribute to Dr. Ephriam McDowell, depicting the world's first successful ovariotomy; "Beaumont and St. Martin," honoring Dr. William Beaumont, who pioneered in the study of the stomach's digestive functions; "Osler at Old Blockley," in honor of Sir William Osler, pioneer teacher of clinical medicine, and "Conquerors of Yellow Fever," a tribute to Drs. Walter Reed and Carlos Finlay, whose work made possible construction of the Panama Canal, vital wartime lifeline.

Twelve paintings in the series are contemplated, one to be unveiled each year.



#### MOBILE OPTICAL UNITS FOR ARMY

Delivery to the Army of six mobile optical units designed to repair or replace spectacles for oversea fighters and thus keep their eyes keen for action was announced recently by C. O. Cozzens, vice president and general manager of the American Optical Company.

The six units, he said, carry 162,000 spectacle lenses and 43,000 frames together with optical machinery and equipment for preparing and fitting the glasses.

He said that each unit, manned by a crew of seven Army optical technicians, is equipped to care for the optical needs of a field army of 300,000 men and that several of the units already have been shipped by the Army to oversea theatres of war.



#### CARE OF WOUNDED BY ARMY-NAVY MEDICAL SERVICES EXTOLLED BY SQUIBB IN SERIES OF ADVERTISEMENTS

The bravery and skill of the Army and Navy medical services and the marvelous new drugs that are saving the lives, rehabilitating the bodies and alleviating the pain of men wounded in action are extolled in a series of advertisements in national magazines sponsored by E. R. Squibb & Sons, manufacturing chemists.

Illustrated with authentic action photos from the Army and Navy, as well as posed pictures in training hospitals, the advertisements point out that 97 out of 100 men in evacuation hospitals during the North African campaign didn't die, that it's 37 to 1, based on present statistics, that men wounded in Navy action won't die, and that men wounded in action often are under skilled medical care within ten minutes after they are injured.

Three reasons are given, quoting the Surgeon General of the Army, for so many lives being saved—blood plasma, skillful surgery and sulfa drugs, in that order. Attention is called to a product newer than plasma—human serum albumin—which is made from blood given at donor centers, but is less bulky, easier to ship and use, and responsible for amazing recoveries from shock and burns.

The advertisements appear under the generic title of "Miracles of the Battle front," and are designed to acquaint the public with the heroic work of the medical services of the Army, Navy, Coast Guard and Marines, as well as to call attention to some of the life saving, pain relieving drugs that are being used. The advertisements were planned and prepared with the cooperation of the medical services. Six insertions, extending into 1944, are scheduled in "The Saturday Evening Post," "Good Housekeeping," "Life" and "Hygeia."



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therapy was learned through the cooperative studies with leading independent endocrinologists which the Squibb Laboratories made possible.

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Dr. Charles F. McKhann, who has for several years been on the faculty of the University of Michigan, has resigned from that institution to accept a position as Assistant to the President of Parke, Davis and Company. Dr. McKhann will devote his time entirely to the scientific activities of the company. He assumed his new duties October 15.

At the University, Dr. McKhann has held the positions of Professor of Pediatrics and Communicable Diseases in the Medical School, and Professor of Maternal and Child Health in the School of Public Health. He has also acted as Consultant to the Secretary of War in the Control of Epidemic Diseases.

Dr. McKhann has had an interesting and exceptional background of experience. During the summer of 1941, previous to coming to the University of Michigan, he acted as Consultant to the Board of Health, Territory of Hawaii. From 1936 to 1940 he held the position of Associate Professor of Pediatrics and Communicable Diseases at Harvard Medical School and Harvard School of Public Health. Before that he spent a year as Visiting Professor of Pediatrics and Communicable Diseases at Peiping Union Medical College, Peiping, China.

Since 1930 he has conducted and directed research on communicable diseases, immunology, renal diseases, nutritional diseases, and on certain phases of toxicology. He developed and introduced immune globulin and has contributed to the development of several other products.



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\* \* \*

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(as you, Doctor, know better than most)



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## DUVAL COUNTY AUXILIARY

Mrs. Charles F. Henley, 2419 Pineridge Road, was hostess at the first fall meeting of the Woman's Auxiliary to the Duval County Medical Society, on Thursday afternoon, October 7.

Reports of work done during the summer months and plans for work to be done in 1943-44 were given by committee chairmen.

Special interest was centered on the report given by Mrs. Henley, defense chairman, and her co-chairman, Mrs. George Richardson, concerning their work at Atlantic Beach and Camp Blanding, where day rooms were furnished and equipped with games and radios for medical units, members of the Duval County Medical Society contributing to the expense involved. Letters of appreciation from the commanding officers of each unit were also read by the secretary.

Mrs. F. W. Krueger, state president, reported the need of toys for the Jacksonville Community House and requested that Mrs. John H. Mitchell, philanthropic chairman, and her committee, interest the Auxiliary in supplying this need. Mrs. L. M. Wachtel volunteered to assist Mrs. Mitchell with this work.

Letters of appreciation for subscriptions to Hygeia Magazine donated by the Auxiliary were read from West Riverside, Fishweir, Fairfield, and Mattie V. Rutherford Schools.

Mrs. S. M. Copeland urged the cooperation of all members in helping with the surgical dress-

ings for the Women's Field Army for Cancer Control at the Congregational Church every Wednesday morning from ten to twelve o'clock. She announced that supplies for this work were being donated by the Red Cross and all the wholesale tire dealers, and the Motor Corps donates its services for the transportation of materials.

A lovely social hour followed at which time tea was served by the hostess. Approximately 35 members were present including the wives of service men.

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## SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Eugene G. Peek, Ocala.....	Shaler Richardson, Jacksonville.....	St. Petersburg, Apr. 13-14, 1944
Florida Medical Districts:			
—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
—Northeast .....	L. Y. Dyrenforth, Jacksonville....	" " "	Ocala, Postponed
—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
—Southeast .....	William Y. Sayad, W. Palm Beach....	" " "	Miami, Postponed
American Medical Association.....	James E. Paullin, Atlanta, Ga.....	Olin West, Chicago .....	Chicago, June 12-16, 1944
Northern Medical Association.....	W. T. Wootton, Hot Spgs., Ark.....	Mr. C. P. Loranz, Birmingham.....	November, 1944
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	Montgomery, Apr. 18-20, 1944
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	Savannah, May 9-12, 1944
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg....	Kenneth Phillips, Miami.....	To Be Announced
Basic Science Exam. Board .....	M. W. Emmel, D.V.M., Gainesville	J. F. Conn, Ph.D., DeLand .....	June, 1944
Dental Society, State.....	E. C. Lunsford, D.D.S., Miami.....	H. L. Cartee, D.D.S., Miami.....	
Derm. and Syph., Soc. of .....	Wiley M. Sams, Miami.....	Lauren M. Sompayrac, Jacksonville	
East Coast Medical Association.....	T. C. Kenaston, Cocoa.....	I. M. Hay, Melbourne.....	
Hospital Association .....	Mr. W. E. Arnold, Jacksonville.....	Miss Katharine Moyer, Lake Wales ..	
Industrial Surgeons, Assn. of .....	Frank D. Gray, Orlando.....	Frank T. Barker, Tampa.....	
Medical Examining Board .....	I. W. Chandler, Avon Park.....	W. M. Rowlett, Tampa.....	
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville.....	Chairman	
Nurses Association, State.....	Miss Florence Jones, Jacksonville	Miss Madalee Hazel, Limona .....	
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville....	C. E. Dunaway, Miami.....	To Be Announced
Pathological Society.....	L. Y. Dyrenforth, Jacksonville....	Iva C. Youmans, Miami.....	To Be Announced
Pediatric Society .....	Ludo von Meysenburg, Daytona B.	Robert Blessing, Ft. Lauderdale...	To Be Announced
Pharmaceutical Association, State.....	Mr. H. B. Douglas, Bonifay.....	Mr. R. Q. Richards, Ft. Myers.....	Miami, To Be Announced
Public Health Association .....	Leland H. Dame, Sanford.....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	John N. Moore, Ocala.....	Walter A. Weed, Orlando.....	To Be Announced
Railway Surgeons' Association.....	Frank D. Gray, Orlando.....	W. C. Page, Cocoa.....	To Be Announced
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales.....	Mrs. May Pynchos, Jacksonville.....	
Attahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine.....	Robert B. McIver, Jacksonville.....	
East Coast Clinical Society .....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	
Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola.....	Kenneth Phillips, Miami.....	
Eastern Surgical Congress.....	Alton Ochsner, New Orleans.....	B. T. Beasley, Atlanta.....	
Winnipeg River Medical Society....	L. J. Arnold, Jr., Lake City.....	H. S. Howell, Lake City .....	

**COMPONENT SOCIETIES BY DISTRICTS**

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	J. Powell Adams, M.D. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		13	12	A-1-45 C. D. Whitaker, M.D. Marianna
Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	48	100%	
Franklin-Gulf		J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	5	100%	
Jackson *Calhoun	R. N. Joyner, M.D. Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	100%	
Walton-Okalooosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	6	100%	
A Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	100%	
Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	James W. Sapp, M.D. Havana	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 8:00 P.M.	40	39	
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		7	100%	
Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	G. H. Warren, M.D. Perry	Last Friday 8:00 P.M.	5	4	
Alachua *Bradford, Gilchrist, Union	Geo. C. Tillman, M.D. 505 W. University Gainesville	Chester F. Ahmann, M.D. 1043 W. Masonic Gainesville	2nd Wednesday 7:30 P.M.	28	25	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
Duval *Clay	T. Z. Cason, M.D. 2033 Riverside Ave. Jacksonville, 4	F. A. Copp, M.D. 411 St. James Bldg. Jacksonville 2	1st Tuesday 8:15 P.M.	194	193	
Marion *Levy	T. Hartley Davis, M.D. 202 Commercial Bk. Bldg. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	28	27	
Nassau	Geo. A. Dame, M.D. Fernandina	E. F. Waite, M.D. Fernandina	2nd Wednesday 8:00 P.M.	9	100%	
Putnam	J. Worth Brantley, M.D. Grandin	C. M. Knight, M.D. Palatka	2nd Tuesday Even Months 7:00 P.M.	9	100%	
B St. Johns	Alfred W. Norris, M.D. Flagler Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	G. E. Christie, M.D. Box 151 Titusville	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	100%	
Lake *Sumter	Louis R. Bowen, M.D. Eustis	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	100%	
Orange *Osceola	T. E. McBride, M.D. Apopka	John A. Pines, M.D. 106 E. Central Ave. Orlando	3rd Wednesday 8:00 P.M.	90	85	
Seminole	Geo. H. Putnam, M.D. Touchton Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	13	100%	
Volusia *Flagler	L. von Meysenbug, M.D. Box 3356 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	43	42	
Hillsborough	T. C. Maguire, M.D. 104 S. Collins St. Plant City	Curtis B. Jefferson, M.D. 818 First Nat. Bk. Bldg. Tampa 2	1st Tuesday 8:00 P.M.	105	99	B-4-44 D. T. McEwan, M.D. Orlando
Manatee	M. M. Harrison, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	14	100%	
Pasco-Hernando- Citrus	W. W. Jones M.D. Dade City	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	11	100%	
Pinellas	J. A. Hardenbergh, M.D. 404 Power & Light Bldg. St. Petersburg 4	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg 4	1st and 3rd Fridays 6:30 P.M.	104	103	
Sarasota	O. H. Cribbins, M.D. 138 N. Link Sarasota	A. O. Morton, M.D. Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	19	100%	
DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	100%	
Lee *Collier, Hendry	H. Quillian Jones, M.D. 18 Leon Bldg. Fort Myers	W. H. Grace, M.D. Box 907 Fort Myers	3rd Tuesday 7:30 P.M.	17	100%	
Polk	T. G. Simmons, M.D. Corlett Bldg. Auburndale	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	63	100%	
Palm Beach	K. Montgomery, M.D. Guaranty Bldg. W. Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	4th Monday 8:00 P.M.	68	64	D-7-45 William Y. Sayad, M.D. West Palm Beach
St. Lucie- Okeechobee-Indian River-Martin	Francis A. Gowdy, M.D. Box 745 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	100%	
Broward	D. W. Harris, M.D. 420 Sweet Bldg. Ft. Lauderdale	O. C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	2nd Wednesday 8:00 P.M.	41	100%	
Dade	H. L. Pearson, M.D. 416 Ingraham Bldg. Miami	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami	1st Tuesday 8:30 P.M.	340	327	
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P.M.	5	100%	
D						D-8-44 Elbert McLaury, M.D. Hollywood

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DECEMBER, 1943

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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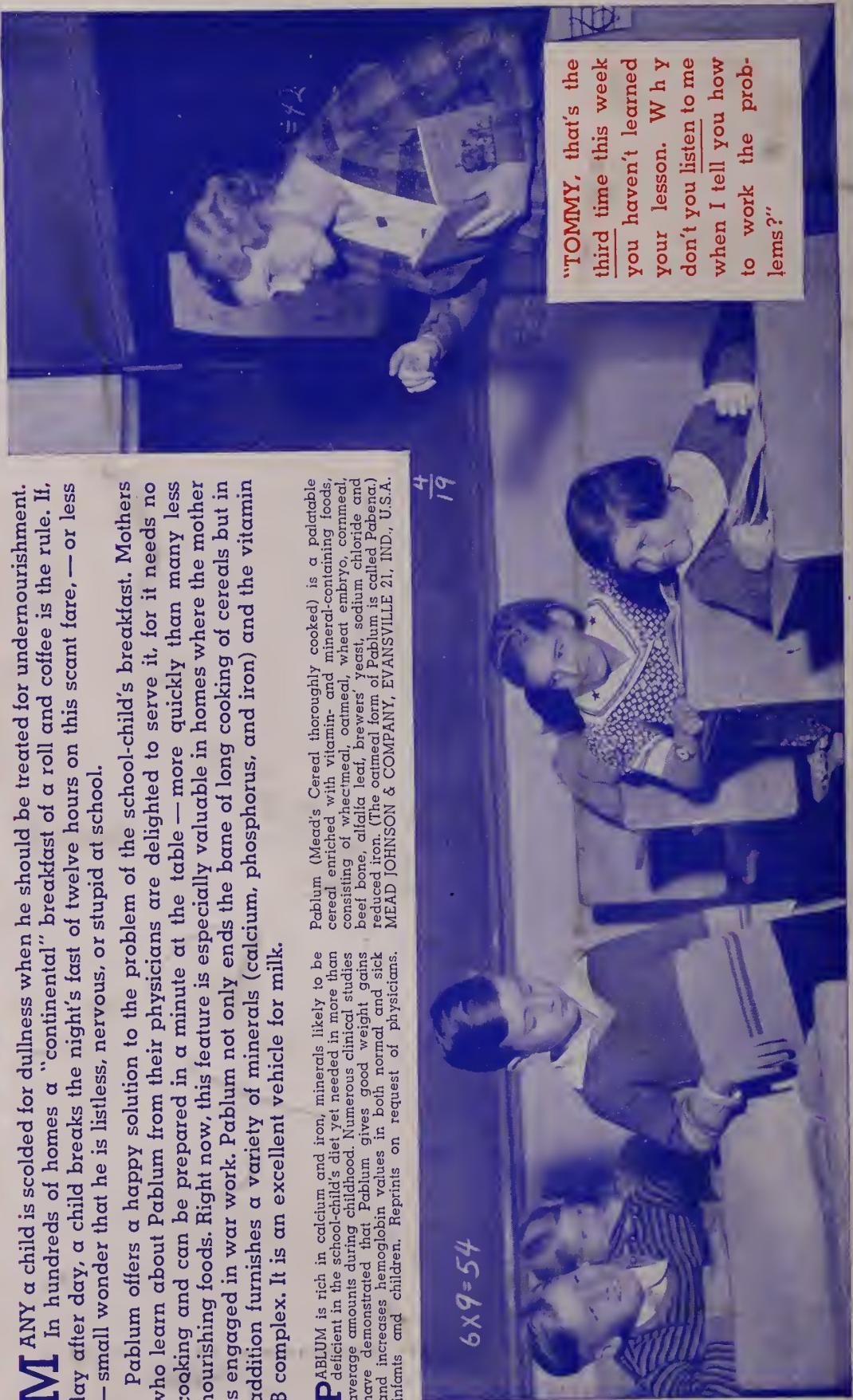
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Vol. XXX

JANUARY, 1944

No. 7

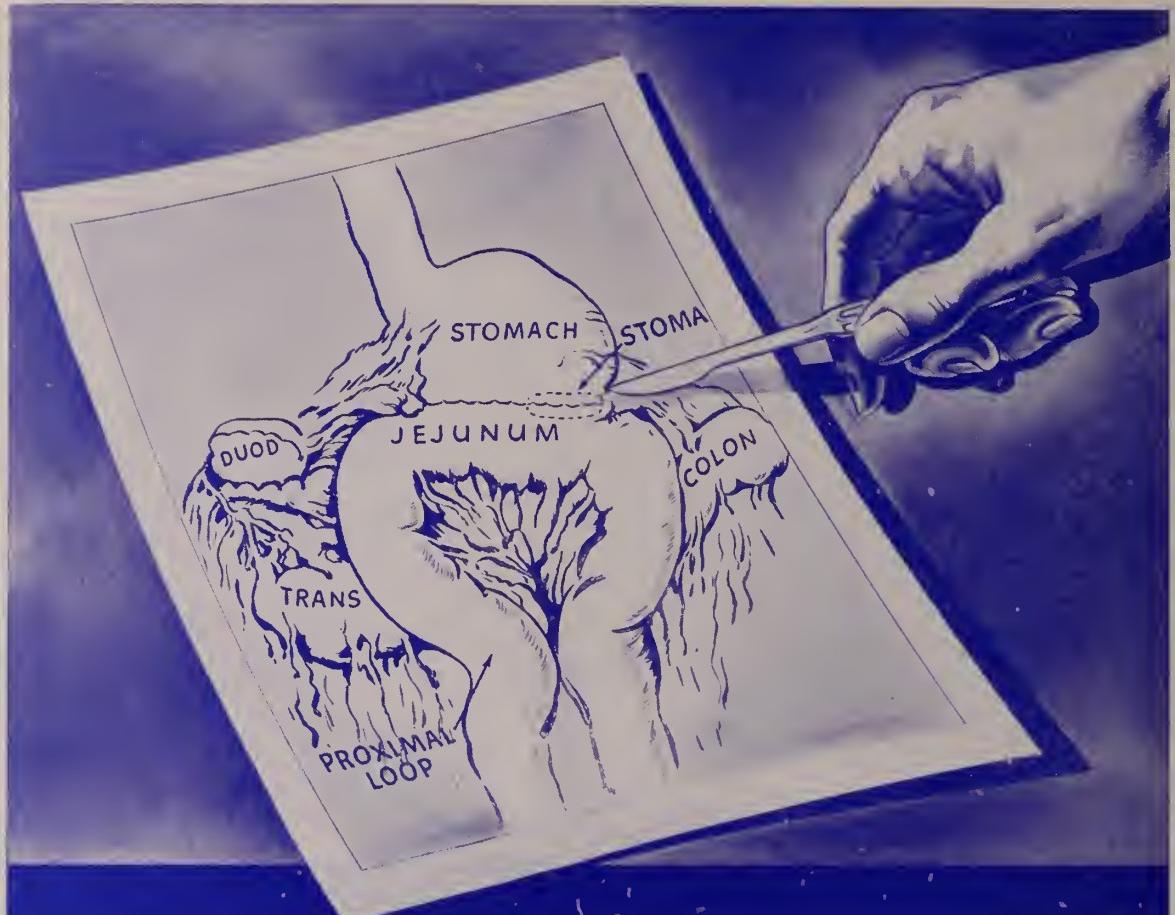
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- 1.** MARSHALL, S. F., and DEVINE, J. W., Jr.: Gastrojejunul Ulcer, *S. Clin. North America*, 74:761-761 (June) 1941.  
**2.** FAULEY, G. B.; FREEMAN, S.; IVY, A. C.; ATKINSON, A. J., and WIGODSKY, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, *Arch. Int. Med.* 67: 563-578 (March) 1941.



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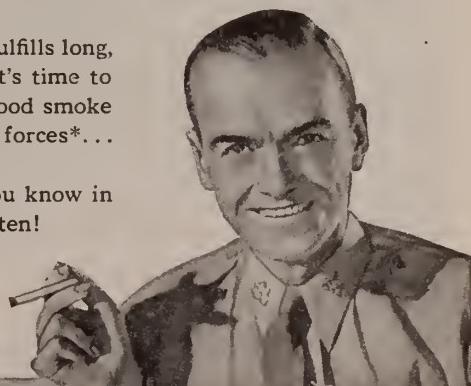
then the paradoctor's command: "Stand to the door!" But it is he who leads them off...first overside...first to face the unknown perils that lie below.

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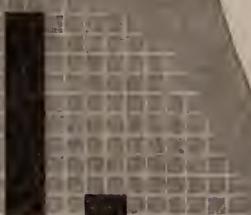
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## CONSIDERATIONS FOR THE BETTER UNDERSTANDING OF THE USE OF THE BLOOD BANK

### REPORT OF FOUR CASES

H. H. WHITNEY, M. D.  
TAMPA

It is now common knowledge that it is possible to store blood plasma in the liquid, frozen and dried forms in large quantities in hospitals or blood banks. Of the three, the liquid form is the most economical to produce and it is usable for approximately one year. The frozen form has a longer period of usefulness and has the advantage of carrying less risk of contamination by virtue of being frozen. Its period of usability is unknown. The dried form is the most expensive to produce. Plasma in this form is stable over a long period of time even under unfavorable circumstances; the expiration date for its use is five years.

As early as 1918 Gordon R. Ward<sup>1</sup> of England suggested the use of citrated plasma in the treatment of shock and made the observation that death from hemorrhage is not due to lack of hemoglobin but to loss of fluid. He also pointed out that one of the chief troubles in the use of whole blood is that the recipient's plasma might hemolyze the corpuscles of the donor. The list of workers who have since advocated the use of blood plasma has grown increasingly long.

The advantages of blood plasma are:

1. It does not add to the erythrocyte concentration when hemoconcentration is present.
2. It is immediately available.
3. Blood grouping can be disregarded.

The chief and outstanding indication for the use of blood plasma in the treatment of surgical cases is shock, usually shock that is secondary to a previous condition such as hemorrhage, severe burns, intestinal obstruction, gastrointestinal hemorrhage, or some infections. It has also been shown without question to be of great benefit in the healing of wounds by maintaining the protein content of the blood at a normal level and thus counteracting edema in the tissues. I shall pass

over certain other indications, such as nutritional edema, nephrotic syndromes, certain cardiac states and other hypoproteinemic states for discussion by those better qualified. I desire, however, to mention a few salient features of shock for an understanding of this state is necessary for the intelligent use of the blood bank.

The mechanism of shock is not entirely understood, but it is clear that the plasma of the blood seems to diffuse out through the walls of the capillaries and the arterioles and to stagnate in the tissue spaces. It would seem to be an especially rapid permeability of the walls of the blood vessels of a strange neurogenic origin. As some one has said, it is as though the swift torrent of a river suddenly left its rocky bed and crossed a sandy desert. This deflection of streams happens in certain arid areas, and the water in the river beds disappears. There is a slow percolation through the sand in the direction of a lower level, but no water is in sight; if the sand is level, there is practically no flow at all. In shock the action of the fluid blood seems to be the same. It disappears, to a great degree, from the blood vessels, leaving a weak and rapidly beating heart pulsating frantically on an inadequate volume of hemoconcentrated blood. Thus it is that replacing the fluid volume in cases of shock often produces dramatic results, and in some cases a nearly normal circulation is reestablished almost immediately.

This syndrome may be arbitrarily classified into primary and secondary shock. Primary shock is generally considered to be of neurogenic origin and is to be differentiated by the facts that the extremities are warm and that there is less loss of blood volume. In secondary or hematogenic shock there is pronounced vasomotor inhibition causing a greater discrepancy between the capacity of the vascular tree and the circulating blood volume. Actually, the one is a continuation of the other.

The picture of secondary shock is so important that it can scarcely be repeated too often. There is a profound fall in blood pressure, especially in pulse pressure; pallor and coldness of the skin, cyanosis, fall in body temperature, rapid shallow respirations and small rapid pulse are present. Veins are collapsed and often must be cut down on

Medical Director and Surgeon, Hillsborough County Home and Hospital.

Read before the Hillsborough County Medical Society, Tampa, Nov. 3, 1942.

in order to give the plasma. Wounds bleed slowly or not at all. Thirst, low urinary output, and at times edema are other symptoms. Laboratory findings are hemoconcentration, acidosis, hyperglycemia and increased nonprotein nitrogen. Cardiac failure should never be confused with this syndrome of shock. One point of differentiation may be mentioned. The cardiac patient does better in a sitting or semi-sitting position. The patient in shock does much better with the head lower than the body and the extremities elevated.

It would appear from the work of Cohn<sup>2</sup> and his group at Harvard that the albumin in the blood is responsible for 85 per cent of the anti-shock qualities of the blood serum. There has been some controversy as to the relative merits of blood plasma and blood serum in the treatment of shock, but when they are properly prepared, the results seem to be comparable. Incidentally, blood plasma is the supernatant fluid which separates from the cellular elements when an anticoagulant is added to blood. Blood serum is the liquid portion of the blood that separates when blood clots. Plasma contains fibrinogen; serum does not.

Unfavorable reactions occasionally occur in the use of blood plasma, usually due to faulty technic in preparation or to pyrogens, which are heat-stable substances produced by the growth of bacteria and which cannot be removed by distillation or by filtration. It has also been shown that some plasma is toxic to certain persons, and Devine and State<sup>3</sup> at the University of Minnesota suggested that a negative intradermal skin test will rule out a possible reaction to plasma. Metzger<sup>4</sup> stated that this observation was contrary to his experience. Reaction occurs, however, in probably less than 1 per cent of cases.

The chief indication for the use of the blood bank is shock. Shock is produced not only by trauma but by many other causes, such as burns, severe cold, heat stroke, irradiation sickness, serum sickness, anemias, poisons, severe infections, dehydration, severe pain or emotional stress, and spinal anesthesia.

In intestinal obstruction there is a great diminution of blood plasma. Abbott and Mellors<sup>5</sup> at Western Reserve obstructed the bowel in dogs at various levels along the intestinal tract. The plasma fluid range was from 66 to 68 per cent of normal in from two to three days. The higher the obstruction, the earlier the death of the dog and

the greater the dehydration. In pyloric obstruction the total amount of circulating blood was reduced as much as 45 per cent because of diminished plasma volume. In obstruction of the terminal portion of the ileum the volume range was from 50 to 70 per cent of normal. In dogs receiving food and water with obstruction in the small bowel dehydration was much more rapid than in controlled dogs when nothing was given. This difference was apparently due to frequent vomiting. In colonic obstruction there was extreme dehydration after an interval of a week, and the dogs with this type of obstruction were allowed food and water. Findings at autopsy were those of severe shock. Practically all of the plasma had left the blood vessels. There were hemorrhages in the lungs and small intestines with pronounced edema and congestion of the lungs and abdominal organs. No peritonitis and no perforation of the bowel occurred.

In the general treatment of shock the first measure is prophylaxis. A case in which the patient is exposed to obvious and precipitating factors should be treated as one of potential shock without waiting for the onset of the clinical symptoms. Thus in a case of extensive injury or mutilation of the tissues, with or without the loss of blood, the patient should not be submitted to operative treatment without a dose of from 250 to 500 cc. of the undiluted plasma.

In the treatment of actual shock the rule is to give an adequate amount early. Twenty-five per cent, or 1 liter in man, of the blood volume is lost in mild shock. In severe shock this amount is doubled. It is obvious then how inadequate is the use of only small amounts of blood plasma in severe shock. In the early stages of shock the treatment is usually a simple and successful procedure, but in the late stages the converse is true, which can well be understood if one thinks back for a moment on the mechanism of shock. Actually the hemoconcentration and increased viscosity of the circulating blood result in a progressive peripheral anoxia with resulting great capillary damage. A vicious circle is thus set up with still further loss of blood plasma. A sudden increase in hemoglobin content indicates, almost surely, hemoconcentration. At this point, with increasing hypoproteinemia, crystalloid solutions are contraindicated as is whole blood, because of hemoconcentration. In the late cases of shock, 750 to 1,500 cc. of the undiluted plasma must be used

rapidly with only a fair chance of success. It is much better to give 500 cc. of plasma in the first two hours of shock than to give twice as much four or six hours later. Hemoconcentration occurs several hours before a critical lowering of the blood pressure.

In cases of chronic loss of plasma protein or of greatly diminished protein intake an extreme hypoproteinemia may develop. With plasma protein less than 4 per cent, the direction of flow of the blood protein, because of the diminished colloidal osmotic pressure, is into the tissues. Intravenous administration of plasma raising the percentage above 4 per cent reverses this flow, the capillaries acting as a semipermeable membrane. Thus it is that edema may often be quickly cleared up by the use of plasma. If the veins are difficult to find, as is sometimes the case in the presence of edema, good results can be obtained by giving the plasma intramuscularly.

In the treatment of burns most spectacular results can be obtained by the use of blood plasma, but usually large amounts are necessary. A burn on the forearm, for example, can produce a loss of 7 Gm. of protein within the first four hours. In treating severe burns it is necessary to use from 3 to 6 L. of blood plasma in the first twenty-four to forty-eight hours and after that from 1 to 2 L. a day as seems indicated by the red blood cell count, hemoglobin estimation, blood pressure and protein estimations. It is also well to remember that following a burn severe anemia may develop making it advisable to use whole blood as well as plasma.

It is wise not to wait for a drop in blood pressure to diagnose impending shock, but if there is a drop in blood pressure, it is a good index by which to judge the severity of the case and the corresponding dose of plasma that is indicated. In shock due to hemorrhage it is well to remember that oxygenation of the tissues may be maintained with as little as 2,000,000 red blood cells per cubic millimeter provided there is sufficient blood volume to circulate them.

Usually the rate of intravenous administration of plasma is from 4 to 8 cc. per minute, but in severe cases when a life seems to be balanced against time, it should be given as rapidly as possible, even through two veins at once.

The four cases described typify the use of the blood bank.

#### REPORT OF CASES

Case 1.—A woman with a frozen pelvis was operated on under ether anesthesia. The case was about as difficult as such cases can be with everything in the pelvis plastered against everything else. Bleeding had started near the bottom of a tubo-ovarian abscess in the depths of the pelvis. It was extremely difficult to control, and the patient left the operating room in poor condition. Coramine and adrenalin were used as stimulants without success. The patient was in the early stages of shock. A pint of human plasma was given with  $\frac{1}{4}$  grain of morphine. The response was immediate and bridged the gap between the surgical measures and a blood transfusion the following morning. The pulse rate dropped from 120 to 90 following the administration of the blood plasma. Recovery thereafter was complete and uneventful.

Case 2.—A woman aged 54 had a hysterectomy because of intractable menstrual bleeding. The blood pressure was 200 systolic and 110 diastolic. She was given a general anesthetic. The operation was easily performed and in no way remarkable. There was no loss of blood, and the appendix was not removed. The time required was less than twenty minutes, and the patient left the operating room in good condition. For no apparent reason there suddenly developed severe shock. The hands, feet and face became cold and clammy; there was profuse sweating with pallor and labored respiration. The pulse became very weak, and the rate was 120. Two hundred and fifty cc. of blood plasma was given through a cannula with no appreciable results. One hour later 500 cc. was given with excellent results. This was followed by 500 cc. of 10 per cent glucose solution. A blood transfusion, which had been ordered for the following morning when the typing could be completed, was unnecessary. The patient made an uneventful recovery.

Case 3.—A man who had received three stab wounds, one of which obviously penetrated the cardiac muscle, is now in the hospital. When he was admitted about midnight, he was pulseless and unconscious. Death seemed almost inevitable. Nevertheless, a vein was hurriedly exposed, and 500 cc. of plasma together with 1,000 cc. of warm normal saline solution was rapidly introduced. Orders were left for the preparation of the operating room for an operation on the heart the following morning in the event that the man was still alive and still bleeding. The next morning there was such a decided improvement in his condition with the bleeding entirely stopped that surgical intervention was not considered. He made still further improvement in the next few hours and now after two days is on the way apparently to certain recovery.

Case 4.—A woman aged 64 was in an extremely serious condition with a total loss of function of the left kidney, as shown by pyelogram. She had a tremendous bed sore and was in the hospital for two weeks while an attempt was made to build her into something like a decent operative risk. This was entirely unsuccessful, and it became evident that she would die of toxemia unless the abscessed kidney was removed. Under spinal anesthesia using 150 mg. of novocain, nephrectomy was done. The operation was difficult because of dense fibrous adhesions to the peritoneum and to the perirenal tissues and also because the kidney was three times normal size. It was filled with pus, and I removed an enormous stone from the pelvis and calices postoperatively. There was little bleeding, and the condition of the patient was fair when she left the operating room. Six hours later extreme shock developed. The blood was quickly typed, and because of the presence of anemia I ordered the administration of 500 cc. of whole blood from the bank. The next morning she was completely out of the state of shock and twenty-nine days later she was doing remarkably well when she suddenly died. Autopsy was not obtained. This patient was given the whole blood because secondary anemia was known to be present.

## CONCLUSIONS

The blood bank is a new and powerful addition to the armamentarium of the physician, as illustrated by the four cases presented. If he does not take advantage of it, certainly in the more obvious cases, the patient is bound to be the loser.

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5906 N. 30th St.



### FATALITY FROM AIR EMBOLISM FOLLOWING ATTEMPTED ABORTION

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AND  
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Believing the subject of air embolism is of sufficient importance to direct attention to it again in the literature, we herewith report a case coming under our observation on April 19, 1943. A 40 year old quadripara, approximately seven



Figure 1

months pregnant in her fifth pregnancy, was found dead in bed with the described apparatus (fig. 1) inserted tightly into the cervix.

The bag and tubes were new, clean and dry. The bag (1) was collapsed. The cap (2) connected to the tubing was screwed in airtight. The stopcock (3) was open and was positive. A FS. 24 catheter (4) had been rubber-cemented airtight to the end of the tube. With the cap screwed in place and the stopcock open, the bag was easily distended retrograde by mouth. No pump or other apparatus was found.

We visualize that she had inserted the tube in the cervix, where we found it tightly wedged, opened the cock and squeezed the bag between her hands, thereby ejecting a considerable amount of air under pressure. Our investigation of the body and surroundings indicated that she was alone, that death ensued within a few minutes and, further, that the idea was self abortion.

Immediate autopsy showed an apparent seven months' pregnancy to exist. The objective feature on opening the body was a distended crepitant uterus with all lacunas and uterine appendages filled with air. The placenta had been perforated by the catheter and rent asunder by a powerful air blast. Air in a great amount, consequently, had entered the venous circuit, filling the lacunas so fully that the uterus was emphysematous with cut sections, resembling goose quills, almost completely air-filled. Air was found in the veins of all uterine appendages and in considerable amount (approximately several hundred cubic centimeters) in the vena cavae. The right side of the heart presented a truly impressive spectacle, being distended with a foamy blood froth, and air globules and columns in the sections of vessels of both lungs indicated a blocked pulmonary circulation from massive air emboli.

The mode of death was obvious. An autopsy of the head was refused by the family. We found nothing wrong with the cardiac muscle. There were no air emboli in the coronary arteries, and there were no infarcts. There was no direct connection between the right and left sides of the heart (foramen ovale). The rest of the organs of the abdomen and chest were essentially normal.

Reynolds and Cutler<sup>1</sup> in 1934 reported a similar case and collected 49 cases of death from air embolism due to attempted abortion. Wolffe and Robertson<sup>2</sup> in experimental air embolism

found that the effect of air is that of a circulatory tampon blocking the pulmonary circuit, but they believed the amount of air accidentally introduced into human beings incident to intravenous injections should occasion no clinical manifestations. Devas,<sup>3</sup> however, in 1942 advised that there is distinct danger from a large quantity of air being injected in transfusion apparatus and devised a method of prevention.

Apparently air embolism occurs more frequently than is realized for Feiner<sup>4</sup> in 1942 reported two fatalities in 706 consecutive cases in which tubal patency tests were made, and Weyrauch<sup>5</sup> in 1940 observed a fatality from perirenal insufflation. Walsh and Goldberg<sup>6</sup> in 1940 observed 2 cases in which blindness occurred as a complication of pleural pneumolysis. Weitzman and Cohen<sup>7</sup> in 1937 reported a case in which the Rubin test was made with fatal results, and Stroh and Olinger<sup>8</sup> reported a fatality from air embolism on the seventh postpartum day when the patient first assumed the knee-chest position. Redfield and Bodine<sup>9</sup> observed 2 cases of air embolism following the patient's assumption of the knee-chest position and advised its discontinuance since it constitutes a dangerous procedure in the early weeks of puerperium. Dible and his associates<sup>10</sup> in 1938 reported 2 fatal cases of air embolism, one incident to urethroscopy and the other to tubal insufflation. These authors concluded that air in excess of 100 cc. injected rapidly may cause death and advised that this amount not be exceeded in the Rubin test.

Hamilton and Rothstein<sup>11</sup> in 1935 reported that air embolism occurs in about 1 in every 500 to 1,000 pneumothorax treatments. They found in the literature references to a fatality from the injection of 300 cc. of air into the bladder and concluded from their study that air embolism is a clinical entity that may be diagnosed. They distinguished between two types of the phenomenon, one in which air enters the peripheral veins and the other in which it enters the pulmonary circuit. In the first type, symptoms are produced by air in the right side of the heart, and the condition has been encountered in practically every surgical field, notably in surgery and wounds of the neck. This association is present because there is a negative pressure in the great vessels of the neck during inspiration, even in the prone position. Symptoms are proportionate to the amount of air sucked into the veins and clinically they vary from dyspnea and

cyanosis to coma, cardiac arrhythmia, apnea and death. Symptoms in the second classification are caused by the presence of air in the cerebral vessels. Most of the cases reported in this category resulted from artificial pneumothorax, surgical measures and injury of the chest wall and the lungs.

The mechanism of death as set forth by Dible and his associates<sup>10</sup> is that of an air lock in the right chamber of the heart blocking the pulmonary artery and arresting the pulmonary circulation, cardiac infarction and filling of the coronary arteries, and cerebral air embolism. They also concluded that the two circulations must be considered separate. In the absence of a direct communication between the right and left sides of the heart, coronary occlusion is ruled out in massive embolism on the right side. On the other hand, when air directly enters the pulmonary circuit, the coronary arteries may be involved with filling of the coronary vessels, cardiac infarction and the train of symptoms referable to these processes. The mechanism of death in our case was clear in that there was an air lock on the right side of the heart and blockage of the pulmonary circuit, which caused death within a few moments.

The physiologic change in this type of fatality is described by Hamilton and Rothstein<sup>11</sup> as due to cardiac inefficiency affecting especially the right side of the heart. As air is most easily compressed, the valves are not properly opened, and the circulation comes to a standstill. This occurrence explains the churned frothy appearance of the contents of the right side of the heart. To this can probably be added the development of an acute hypertension of the lesser circuit due to the diffuse capillary blockage of the pulmonary vessels by air bubbles.

Air embolism is believed by some authorities to be fatal in 15 per cent of cases, and the estimate of others is as high as 50 per cent. The patients surviving fifteen or more minutes following the accident probably have the best chance of recovery, and after an hour there is an excellent chance, even if paralysis or coma has been or is present. Focal neurologic lesions clear up well, but there are recorded instances of permanent disabilities, notably partial blindness.

It is the duty of the profession to warn the laity of danger inherent in attempted abortion. In other accidents treatment consists of keeping the patient's head level below that of the rest of

the body for twenty-five minutes and the usual shock treatment. Aspiration of the right side of the heart has been advocated, but is not recommended.

#### SUMMARY

Attention of the profession is directed to the danger of air in any appreciable amount entering the human body either in cavities or through the circulation, especially the venous circulation in view of the increased use of intravenous medication in the hands of nurses and others in these shorthanded war times. It is well to pause and consider the great risk run here. The responsibility of fatalities incident to the Rubin test, especially if pregnancy exists, is mentioned. The danger of perirenal insufflation, the knee-chest position in the early puerperium and insufflation of air into the bladder or kidney or any other closed cavity of the body is discussed. A fatal

case of air embolism following attempted abortion is reported.

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#### ABSTRACTS OF MEDICAL ARTICLES

VITAMIN B IN EMESIS AND HYPEREMESIS GRAVIDARUM, HART, B. F., WINTER PARK, AND TORPIN, RICHARD, AUGUSTA, GA., *J.M.A. GEORGIA* **31**: 368-371 (Sept.) 1942.

A series of 48 cases in which pregnant patients complaining of nausea and vomiting, were treated with components of vitamin B is analyzed. Some were in the earlier and some in the later periods of pregnancy. Many, subsisting on a borderline diet, were probably subclinical pellagrins, and 4 were known pellagrins. In some instances vomiting had doubtless exhausted the supply of vitamin B. The metabolic increase and perversions of pregnancy were regarded as probable precipitating factors. Six of the patients were hospitalized. No attempt was made to regulate the diet or mode of living of the ambulatory patients.

TRN6P, nicotinic acid, thiamine chloride, riboflavin, B<sub>6</sub> and pantothenic acid were administered, singly or in combination, in varying doses, in some instances orally and in others parenterally. The authors concluded that the vitamin B factors seemed to be of definite value in a large number of the cases. Some patients ceased vomiting entirely, others experienced partial relief, and a few were not benefited. It was noted that the severely ill patients were usually hungry after large doses of the vitamin had been administered intravenously although the vomiting did not cease at once.

WAR TIME MANAGEMENT OF GONORRHEAL URETHRITIS BY CHEMO-FEVER THERAPY, PHILLIPS, KENNETH, AND MUNDORFF, ALICE B., U. S. N. R., UROL. & CUTAN. REV. **47**: 374-378.

In a study of 1,649 cases of gonorrhreal infection of the urethra, observed in the venereal wards of a large United States naval hospital over a period of eighteen months, 1,613 cases of resistant gonorrhreal urethritis were satisfactorily analyzed with respect to total loss of time from duty during active warfare.

The conventional type of treatment with 1 Gm. (15 grains) of sulfathiazole six times daily for one or two weeks was supplemented, when indicated, by three forms of adjunct therapy. One group received foreign protein, initially 0.3 cc. of triple X (Navy) typhoid vaccine administered intravenously followed by repeated or increased doses up to 0.6 cc. in order to attain the elevation of temperature and the three to five sessions desired. Another group received fever therapy by the hypertherm for six sessions with the body temperature elevated to from 103 to 104 F. for four hours. A third group received chemofever therapy by the same method in two sessions with the body temperature elevated to 106 F. for four hours.

In this series the fever therapy at low temperatures and the foreign protein therapy reduced somewhat the length of the period of hos-

pitalization per patient whereas the chemofever therapy at high temperatures produced a startling drop in the length of the period. Chemofever therapy is advocated in the treatment of resistant cases, and its employment is suggested in early cases when it is available under the highly specialized requirements necessary for its safe administration.



PRIMARY OVARIAN PREGNANCY WITH LIVING MOTHER AND CHILD, STRUMPF, I. J., JACKSONVILLE, AM. J. OBST. & GYNEC. 45: 350-353 (Feb.) 1943.

A case of primary ovarian pregnancy in an adult Negro multipara is reported in which a full term living infant was recovered by laparotomy. Noteworthy features of the case include not only the rare type of implantation of the ovum which characterizes such a pregnancy, and the living fetus developed to full term, but also the lack of evidence of abnormality of the child. In addition, the postoperative course progressed satisfactorily, and the mother and child were discharged from the hospital in good condition on the fourteenth day. Pathologic examination, both gross and microscopic, confirmed the anatomic evidence of ovarian pregnancy.



STUTTERING: PRELIMINARY REPORT ON A TREATMENT BY CORRESPONDENCE, LILIENTHAL, HOWARD, NEW YORK, AND JEWETT, RUTH S., WINTER PARK, M. REC. 156: 167-168 (MAR.) 1943.

The attention of the medical profession is directed to a treatment for stuttering conducted by correspondence. This method was originated in 1935 and is based on the premise that relatively few stutterers have physical defects which hinder the normal production of vocal phonetics or inhibit the nerve influence required for articulation. The Emery plan offers a valuable means of self education to the sufferer who recognizes that determination to help himself is essential.

Presentation of the course by a series of informal personal letters, setting forth in simple language the principles employed, makes the treatment readily available to every stutterer, no matter how far removed geographically or financially he may be from metropolitan centers of speech development. The authors outline the method and cite cases coming under their obser-

vation which attest the efficacy of this form of therapy.



THE BIOSYNTHESIS OF THIAMINE IN MAN, AND ITS IMPLICATIONS IN HUMAN NUTRITION, NAJJAR, VICTOR A., AND HOLT, L. EMMETT, JR., BALTIMORE, J. A. M. A. 123: 683-684 (NOV. 13) 1943.

Nutritional experiments on 9 adolescent male youths revealed that intestinal bacteria can produce thiamine.

It is not possible to state at the present time, the authors say, that thiamine requirements can be sustained for an indefinite length of time by such thiamine as is formed by intestinal bacteria. It may be that minute amounts of oral thiamine are needed for the growth of the bacteria which synthesize thiamine. The nature of the synthesizing organisms and the relation of diet to such bacterial synthesis are now under investigation.

The demonstration that intestinal bacteria can synthesize thiamine carries interesting implications for human nutrition, it is pointed out. This phenomenon may explain the discrepancies in thiamine requirements observed by different investigators. The authors say, "Since it is likely that the biosynthesis of thiamine is greatly affected by diet, as is known to be the case in animals, it follows that we must think in terms of requirements on particular diets rather than of requirements in general. It is quite possible that dietary factors other than the thiamine content may explain in part some of the paradoxes in the incidence of beriberi—its frequency among the rice eaters and its relative infrequency among those who subsist largely on other milled cereals. The possibility of controlling thiamine deficiency by means other than thiamine administration remains to be explored." They add that the inhibition of the biosynthesis of thiamine by a sulfonamide drug has an important clinical implication for the physician who uses these drugs.

In their experiments, the authors gave the 9 young men a special diet, gradually reducing the initial thiamine intake of 1 mg. a day. Within from three to five weeks after thiamine had been omitted from the diet, clinical evidence of thiamine deficiency had developed in 4; in 1 there was questionable evidence, and in the remaining 4 no signs of deficiency were observed during a seven week period of observation. Almost no free thiamine was found in the stools of the 4

with deficiency symptoms, a small amount in the stool of the subject with questionable symptoms, whereas large quantities were found in the stools of the 4 without symptoms. When one of the latter was given succinylsulfathiazole by mouth, the free thiamine in the feces disappeared within a week and reappeared a few days after the drug was discontinued. From this and other findings the authors conclude that the thiamine in the stools had its origin in the intestinal bacteria.

  
**PSYCHIATRIC PROBLEMS IN THE ARMY, MENNINGER, WILLIAM C., LIEUT. COL. M. C. ARMY, U. S., J. A. M. A. 123: 751-754 (NOV. 20) 1943.**

The author directs attention to the three major psychiatric problems which face the armed forces. As of first importance he lists the lack of psychiatrists and other trained personnel, and states that short intensive psychiatric training courses for physicians are very much in order, not only to meet the present need but for the tremendous postwar job in this field.

The second major concern confronting every physician, both in and out of the Army, he states, is the number of psychiatric cases which the war experience has disclosed in our general population. The medical and social implications of this group are beyond our present ability to estimate.

The third major problem facing the army psychiatrist, according to this author, is the rapid and most effective disposition of maladjusted persons in the Army. The first purpose of the Army is to win the war, and consequently these soldiers unfit for service must be given over to the care of civilian agencies and civilian physicians with the hope that they will accept the responsibility, and provide treatment for these men in accordance with modern psychiatric concepts.

The psychiatric problems of the Army, Colonel Menninger points out, should be of vital interest and concern to every citizen interested in the war effort and particularly to physicians. They should be of interest, first, because of the great number of men whose Army experience has brought to light their need for medical and particularly psychiatric help. This fact may be vividly portrayed by these figures: an average of from 8 to 10 per cent of the men examined for military service are rejected for psychiatric reasons, and nearly 30 per cent of the discharges from the Army are for psychiatric reasons. In contrast,

only 2 per cent of the medical profession are psychiatrists. The social implication of these figures is enormous, but their importance to the medical profession is even greater. "Every internist," he says, "is aware of the fact that even in normal circumstances in our prewar practice between 40 and 60 per cent of the patients seeking medical help present only functional disturbances."

The Colonel points out that, despite the lack of trained psychiatrists and the lack of facilities, the caliber of neuropsychiatry practiced in the Army is surprisingly good.

  
**THE PROGNOSIS OF ANGINA PECTORIS; A LONG TIME FOLLOW-UP OF 497 CASES, INCLUDING A NOTE ON 75 ADDITIONAL CASES OF ANGINA PECTORIS DECUBITUS, WHITE, PAUL D.; BLAND, EDWARD F., BOSTON, AND MISKALL, EDWARD W., EAST LIVERPOOL, OHIO, J. A. M. A. 123: 801-804 (NOV. 27) 1943.**

The life expectancy after angina pectoris first appears is about twice as long as has been commonly believed, according to the findings of these authors. This statement is based on what is, so far as they know, the first study of this condition that involved a large series of cases followed over an adequate length of time.

A follow-up study was made in 1943 of 497 cases of angina pectoris that were first observed in the years from 1920 to 1930. It was found that of these 497 patients, 445 were dead and 52 were still living. The average duration to death of the 445 was 7.9 years, while the average duration from onset of the disease in the living is 18.4 years. The average duration to date for the combined dead and living is 9.0 years, which, the authors believe, will ultimately increase when all the present survivors succumb, doubtless to a figure approximating ten years, a duration of life about double that at present widely regarded as the expectation of life after angina pectoris first appears. Seventy-six per cent of the deaths were due to cardiac causes. A pronounced degree of nervous sensibility was a favorable influence. Angina pectoris decubitus was observed in 103 (20.6 per cent) of the 497 cases. There were no significant differences in the average duration of the disease to death or in the living between this group and that of the group as a whole.

It is pointed out that "it is helpful for the doctor to know something of the average life

expectation in general in angina pectoris as well as for the patient and his family, "rather than to leave merely the impression that prediction is impossible and that the Sword of Damocles may fall at any moment. Such a state of affairs is for many persons so paralyzing that they are prone to sit for many years awaiting the end, unable to carry on a useful or happy life, or else, hardened by the thought, they may lead a reckless existence which in truth can hasten their end."



A TREATMENT FOR PEDICULOSIS CAPITIS, DAVIS,  
WILLIAM A., NEW YORK, J. A. M. A. 123: 825-826  
(NOV. 27) 1943.

In the introduction to his report, Dr. Davis explains that as a part of a general program to devise methods for the control of typhus fever a systematic study was undertaken with a view to determining the louse-killing properties of various chemical agents. He points out that there are many objections to the older methods for the control of head lice, and says that the ideal method for treating pediculosis capitis should be by a lotion, since only a liquid can easily penetrate the entire hair and leave a residual for prolonged action. The fluid should rapidly kill lice and nits, should not have unpleasant properties such as greasiness, staining or odor and should be both cheap and lasting. As a result of studies on chemical agents which kill lice, a number of lotions have been prepared which meet these needs.

Two lotions, the formulas of which are given, proved to be quite satisfactory on 50 children in an American hospital and on 1,278 civilians in Mexico, who were treated in cooperation with the Mexican Department of Public Health. These formulas are recommended for general use in the control of head lice.



2-ANILINOETHANOL—AN INDUSTRIAL HAZARD:  
PRODUCTION OF METHEMOGLOBINEMIA, BASS,  
ALLAN D.; FROST, L. H., AND SALTER, WILLIAM T.,  
NEW HAVEN, CONN., J. A. M. A. 123: 761-763  
(NOV. 20) 1943.

Because the drug aniline is known to be poisonous, as are its derivatives, the authors point out that the hazard of such intoxication in human beings might be mitigated if special care was taken to name aniline derivatives as such. At least a cautionary label should be applied to warn industrial safety committees of the danger.

They say that, to the best of their knowledge,

it had not previously been established that 2-anilinoethanol, an analine derivative which they say has been improperly named "phenyl ethanamine," causes cyanosis. They cite 2 cases in which men in a commercial plant became cyanotic while using this compound under the name of "phenyl ethanamine."

"Because this problem of toxicity is likely to arise repeatedly as new industrial uses are found for the many related chemical substances which will be available," the authors explain, "this example has been cited."



SULFONAMIDES IN BRONCHIAL SECRETION; THE  
EFFECT OF SULFONAMIDES IN BRONCHIECTASIS,  
NORRIS, CHARLES M., PHILADELPHIA, J. A. M. A.  
123: 667-670 (NOV. 13) 1943.

Combined sulfonamide and bronchoscopic treatment in 10 cases of acquired bronchiectasis resulted in a considerable reduction of daily sputum volume, with favorable alterations in the bacterial flora. The treatment consisted of sulfadiazine given by mouth in courses lasting from four to fifteen days and, as an adjuvant measure to improve bronchial drainage, the bronchi were drained by means of a bronchoscope at intervals of from two to four days during the time the sulfadiazine was being administered.

Dr. Norris believes that the plan of treatment should prove of definite value as a preliminary to certain surgical procedures involving the lungs and that it is probably worthy of trial in cases of well established nonsurgical bronchiectasis. He emphasizes, however, that his data are preliminary and that further study and observation will be required to confirm the impression that the measures described are of actual value.

He points out that the frequency of chronic infectious diseases of the bronchi and the limitations of the various medical measures used in their treatment would appear to justify an investigation of the possibilities of sulfonamide therapy, yet a review of the recent literature reveals only a few brief references to this subject. Although the pathologic changes in many of these diseases are at least partially irreversible, it would seem logical that diminution in the infectious factor should result in improvement.

Spraying of the bronchi with a solution of sulfadiazine was tried in some cases by the author, but with less satisfactory results than those obtained by oral administration.

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## The Journal of The Florida Medical Association

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## ABSTRACT DEPARTMENT ENLARGED

One of the most difficult problems faced by many physicians is to keep up with the rapid strides made in therapeutic research during a period when they are so overworked as to have little time for reading. Few have the time and the stamina to peruse the numerous articles in the weekly Journal of the American Medical Association, specialty publications and the State Medical Journal.

Recognizing the importance to a doctor of each moment he devotes to reading, the Florida Medical Journal, beginning with this issue, is enlarging its abstract department. Heretofore this column contained only reviews of articles written by our members, published elsewhere than in our own journal. Such abstracts will continue to appear. In addition, however, briefs will be run of selected articles from other medical journals. The abstracts, which will undoubtedly form an ever increasingly important part of the scientific section of the Journal, will be placed in the front form, immediately following the original articles.

This rearrangement of the Journal will help solve another problem which has faced the editorial staff for some months. As has been pointed out from time to time, a number of factors have combined to produce a dearth of scientific material. About 30 per cent of our members are with the armed services. Those who remain in the state must take care of a population that has increased phenomenally; they therefore do not have much time to delve into the realm of original research or even to write up interesting case reports. One of our constant sources of good scientific material, the district medical meeting, was en-

tirely cut off when no meetings were held during the past two years. Furthermore, at the last annual state meeting, no papers were presented by our members at the scientific sessions.

It is hoped that this latest change in the Journal will be of benefit to its busy readers, particularly to that large group of members who do not receive the J.A.M.A., and that it will also tide the publication over a critical period in its history.



## VENEREAL DISEASE CONTROL

The Governor of Florida has taken a definite part in the venereal disease educational program which is statewide in scope. Governor Holland has designated the month of January, 1944 as Venereal Disease Control Month. Radio time will be donated by twelve stations throughout the state to emphasize this program and to broadcast forums of interest to the general public. Outdoor billboards, posters, pamphlets, and handbills will be used, and venereal disease educational advertisements will appear in fourteen of Florida's largest newspapers during the month of January.

These are busy days for the wartime physician, but every medical society and physician member should participate in this educational program. All members of the medical profession must do all in their power to curb the rising incidence of venereal disease and to eradicate this internal enemy.

### PROCLAMATION

WHEREAS, it is necessary to the future strength and welfare of our people that their physical and mental health be guarded and constantly improved, and

WHEREAS, plans have been made for the stimulation of interest in and action to combat the inroads which venereal diseases are making into the availability and usefulness of manpower, beginning in the month of January 1944, and

WHEREAS, this undertaking is of great importance and merits the wholehearted support of our citizens and of public and private agencies;

Now, THEREFORE, I, Spessard L. Holland, by virtue of the authority vested in me as governor of the State of Florida, proclaim the month of January

### VENEREAL DISEASE CONTROL MONTH

in Florida and urge the citizens of the State and all agencies able to assist in this work, to call attention to the meaning and importance of the fight against venereal diseases and to take affirmative action leading to the permanent elimination of that dangerous internal enemy.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Florida at Tallahassee, the Capitol, this the 7th day of December, A. D. 1943.

(Signed) Spessard L. Holland  
Governor

### A. M. A. BROADCASTS

Arrangements have been completed with the National Broadcasting Company to resume the series of broadcasts entitled "Doctors at War." This will be the fourth series of broadcasts under the general title of "Doctors at Work" and will be the ninth annual series of dramatized health programs presented cooperatively by the American Medical Association and the National Broadcasting Company.

Owing to radio commitments in connection with the war, the opening of the series has been postponed until January 8. Broadcasts will be given on Saturday afternoons at 5 o'clock, E.W.T. The series will run for twenty-six weeks.

The Medical Department of the United States Army and the Bureau of Medicine and Surgery of the United States Navy have agreed to permit doctors in the armed forces to participate in the programs. The medical departments of both the Army and the Navy will assist in the technical preparations for the broadcasts.



### ARTICLE IN READER'S DIGEST ON ARTHRITIS RAISES FALSE HOPES

In commenting on an article by Paul de Kruif in the Reader's Digest for November entitled "Hope for the Victims of Arthritis," The Journal of the American Medical Association for November 27 directs attention to a letter from Ralph H. Boots, M. D., New York, published in the same issue of the Journal. Dr. Boots points out that both he and R. H. Freyberg, M. D., are referred to in the article and says that "Dr. de Kruif did not ask either Dr. Freyberg's or my opinion regarding our results . . ." He suggests that the article might better have been called "False Hope for the Victims of Arthritis."

The Journal adds:

In 1937 the Council on Pharmacy and Chemistry of the American Medical Association indicated that a product called Ertron, which is a capsule containing some 50,000 U. S. P. units of vitamin D, was not acceptable for New and Nonofficial Remedies. The flamboyant advertising then used for the product was condemned. The Council also said that there was no proof that such large doses of vitamin D are not toxic and it concluded "Critical examination of the reports on the value of vitamin D in the treatment of chronic arthritis reveals little to warrant the belief that the beneficial effects claimed are specific." In the years that have passed, other discussions of the use of massive doses of vitamin D in the treatment of arthritis have been published, including a symposium on the subject before the American Rheumatism Association in June 1942 and a paper by Dr. R. H. Freyberg of the

University of Michigan in The Journal. Dr. Freyberg found the results of the use of such preparations unimpressive. The consensus of the symposium before the American Rheumatism Association was likewise far more negative than favorable to the use of this preparation. In New and Nonofficial Remedies, 1943, the Council summarized the evidence available to the date of publication in the following sentence: "Clinical evidence does not warrant the claim that massive doses of vitamin D are of benefit in chronic arthritis . . ." Nevertheless de Kruif in an article in the Reader's Digest for November conveys to its readers his extraordinary enthusiasm regarding this technic. Apparently the article stimulated hundreds of persons with arthritis to approach their physicians and to request a change from the methods of treatment which were being followed to the use of such preparations. Many of these physicians report that they have received from one hundred to three hundred requests either directly or in writing. Those who attempt education of the public in matters of health and disease have a serious responsibility; they do incalculable harm when they mislead the public."



### PUBLISHED FIGURES ON PHYSICIANS' INCOMES ARE GUESSES

The recently widely published figures on the average gross and net incomes of physicians are little more than guesses, The Journal of the American Medical Association for November 20 points out. The Journal says:

The U. S. Department of Commerce recently issued a release on the incomes of physicians of which the following sentence has been widely published and discussed: "The average gross income reported for 1941 was \$8,524, and the average net income \$5,047." Analysis of the methods by which these figures were obtained reveals that they are little more than guesses. The full report of the study on which they are based is printed in the "Survey of Current Business," issued by the Bureau of Foreign and Domestic Commerce of the U. S. Department of Commerce, October 1943, pages 16 to 20. From this we learn that "questionnaires were sent to a representative sample of physicians who were requested to give information relating to gross and net incomes, costs of practice, age, type of practice, employees, pay rolls, and other selected items during the period from 1936 through 1941." A total of 1,898 returned questionnaires were used, about 1 per cent of the 180,496 physicians reported in the American Medical Directory for 1942, when the survey was made. One hundred of these questionnaires from the southwest were excluded because of "a strong bias . . . in the sample from Texas." For apparently the same reason the returns from Illinois, Indiana and Michigan were not included. There is no explanation of the method by which the sample was selected or any proof that it was representative. It is admitted that there were "special difficulties arising from the impracticability of obtaining a full representation of those of the younger doctors who were withdrawn from independent practice into the armed forces prior to the summer of 1942," but this is purported to have been allowed for by "weighing." In the summary table, returns from only twenty-one states are listed. Among those omitted, in addition to those previously mentioned, are Florida, North Carolina, South Carolina, Tennessee, Minnesota, Missouri and Wisconsin. On this very small foundation, nevertheless, is built an inverted pyramid of deductions, conclusions, diagrams and classifications based on income by age, localities, size of city and gradation of income, all given to the final dollar or to a decimal fraction, which gives a semblance of accuracy which the foundation of facts is entirely too slight to support.

## DICTATED HEALTH

At a time when medical science is performing seeming miracles in the discovery and application of new healing agents and operating techniques, and while thousands of American doctors are away in the armed forces serving America and all mankind, along comes a proposal to socialize medicine as a part of a broad scheme to provide "security" for the general public.

America is a sick nation indeed if it is blind and indifferent to the perils that lie in the formula set in Senate Bill 1161, as introduced on June 3, 1943, by Senator Robert F. Wagner of New York, for himself and Senator James Murray of Montana.

This over-all prescription for "security" consists of 90 printed pages of elaborately-worded and fully detailed plans to take care of practically all the economic, sociological and physical ills of most of the individuals within our borders. It is proposed as an amendment to the already-amended Social Security Act.

Like prohibition, which was foisted on the nation while a large section of our population was on foreign soil, Senate Bill 1161 is a can't-wait measure. If enacted into law by the American Congress, it will become effective on January 1, 1944. In the meantime, millions of American men and women, including many thousands of doctors, nurses and others who will be directly and seriously affected by the terms of this measure, will be out of the country in military service or otherwise preoccupied with the war effort. They will be unable properly to protect their personal rights and their means of livelihood against the threat to turn the efficient, scientific and benevolent American medical system into a political racket, subject to the dictates of a single person.

Space limitations do not here permit detailed comment on all phases of Senate Bill 1161, which will not, you may be sure, provided anything free to anybody at any time, but will cost the American people literally billions of dollars in taxes and assessments.

This all-encompassing and roseate scheme to appeal to the masses, using the something-for-nothing formula, is another attempt, whether intentional or otherwise, to radically alter the American way of life and make the people the slaves of government instead of the government the servant of the people. In its application to medical care and hospitalization, it ignores the clear fact that for years under the free enterprise system, adequate and efficient health, disability and hospitalization insurance has been available to the individual according to his own needs, his own will and his own prerogatives.

In brief, the measure now under consideration by Congress proposes that the Surgeon General of the Public Health Service have full power and authority to (1) hire doctors and establish rates of pay, possibly for all doctors; (2) establish fee schedules for services; (3) establish qualifications for specialists; (4) determine the number of individuals for whom any physician may provide service; and (5) determine arbitrarily what hospitals or clinics may provide services for patients.

There is no public demand for socialistic practices in the field of medicine, or in any other field in America. There can be no possible excuse for arbitrarily placing men of science engaged in basic human welfare work, under political domination. It would be but a mere step farther, and hardly more inconceivable, to place all religion, all education, all industry, all business activity, all art and culture in the hands of a few willful bureaucrats.

The modern doctor practices preventive as well as curative medicine and in addition is a counselor and friend to his patients. His services are rendered to individuals as such—whose ills and problems and needs are individual, distinct and confidential. He works with his judgment and his years of specialized training as well as with his hands. He watches clocks only to be on time and at hand to repair broken bodies and save human lives. He is entitled to just and adequate rewards for his devotion to humanitarian principles and practices. His

fees have never been, and cannot possibly be, regulated on a portal-to-portal basis. He can't go on strike except against his own best interests and his conscience.

Why, then, in the name of common sense and decency, should the entire medical profession, highly respected for its proved efficiency, be made subservient to sociological experimenters, case workers and bureaucrats? Why should public health be menaced by political dictation as to how, when and where medical service should be rendered.

It is later than you think! We urge all our readers to carefully study the special pamphlet published by the National Physicians' Committee for the Extension of Medical Service, which is enclosed with this issue of "Pulling Together." We ask you promptly and strongly to protest against the passage of Senate Bill 1161. It is a ghastly and costly measure that will go a long way toward wrecking the American way of life. Now is the time to defeat it, and it's just as much the fight of every businessman, in fact, every citizen as it is of every doctor. Read the booklet, then tell your representatives in Congress what you think of it and what he, in your judgment, should do about it.

—Pulling Together, Aug. 1943



## THE PURPOSES AND FUNCTIONING OF THE COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS, A. M. A.

The Council was authorized by the House of Delegates of the American Medical Association at its annual session in Chicago in June, 1943. The members of the Council were immediately appointed by the Board of Trustees. Section 4 of Chapter IX of the By-Laws provides that the duties of the Council shall be as follows:

- (1) To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people;
- (2) to inform the constituent associations and component societies of proposed changes affecting medical care in the nation;
- (3) to inform constituent associations and component societies regarding the activities of the Council;
- (4) to investigate matters pertaining to the economic, social, and similar aspects of medical care for all the people;
- (5) to study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates, and
- (6) to develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association.

In the exercise of its functions, this Council, with the cooperation of the Board of Trustees, shall utilize the functions and personnel of the Bureau of Legal Medicine and Legislation, the Bureau of Medical Economics and the Department of Public Relations in the Headquarters Office.

The Council is also bound by the actions of the House of Delegates on the subject of medical care and its distribution, notably the platform adopted in 1937 as amended and amplified in subsequent years by the various resolutions and reference committee reports adopted by the House of Delegates.

In order to carry out these functions, the Council has organized as follows:

*Organization*

Officers.—The Council shall elect annually a chairman, a vice-chairman, and a full-time secretary.

An executive committee of three shall be created, which shall include the Chairman, the Council member of the Board of Trustees, and a third member to be chosen annually from the duly appointed or elected members of the Council on Medical Service and Public Relations. This committee shall exercise such functions as are delegated to it by the Council.

The central office of the Council is to be located in the office building of the American Medical Association in Chicago, Illinois.

The functions of the council outlined in the By-Laws are closely integrated and cannot well be considered separately. To carry them out it is obvious that the Council must have adequate sources of information, maintain close contact with constituent associations and component societies, and establish close relationship with the already existing Bureaus and Departments of the Association.

The Council, therefore, subject to the approval of the Board of Trustees, has decided on the following methods of operation:

1. In carrying out the directive in the By-Laws as to relationship with the other Bureaus and Departments of the Association, the Council has established close collaboration (a) with the Bureau of Medical Economics, which has been asked and has expressed the willingness to do the research on many of the economic problems necessary for the Council's study, and which is well equipped to carry out such research; (b) with the Bureau of Legal Medicine and Legislation. Joint bulletins will be issued with that Bureau on legislative matters. Attempt will be made to effect wider distribution and, if necessary, more frequent publication of such bulletins; (c) with the Department of Public Relations. The Council shall utilize the sources of information of this department and joint bulletins may be issued from time to time with it, and if indicated with other bureaus of the American Medical Association. All planning will be to avoid overlapping of functions and duplication of effort.

2. The Council on Medical Service and Public Relations has extended the sources of information of the American Medical Association on problems with which the Council is specifically concerned. Through its membership and by cooperation with constituent associations and component societies and the utilization of other facilities, the Council will disseminate such information toward effecting its objectives. The Secretary of the Council, with its approval, will undertake such travel as may be necessary.

3. In order that constituent associations and component societies may be kept informed of the activities of the Council, and of proposed changes in the status of medical care, and that the Council may be of assistance to those associations and societies, the Council has requested each State Association to designate an existing

committee or create a new committee to function with the Council on a State level.

Each State organization has also been requested to contact each component society in the State and ask it similarly to designate or form a committee to function in connection with the programs of the Council. Where such organization is feasible, it has been suggested that committees be created along the lines of congressional districts.

Such State and county committees have been urged to keep the Council informed of their local problems and activities.

State organizations also will be requested from time to time to conduct experiments in the various methods of medical care and to inform the Council of their results so that the Council may study and evaluate the experiments and transmit the information acquired to all concerned.

4. The Council feels that under its directive it is its duty to endeavor to evolve such modifications of our present system of medical care as may be necessary to cover all the people and be in accord with the traditions of American Medicine as to high standards of medical care and the American tradition of free enterprise as already outlined in paragraph 1 of the Council's Policies previously published. To accomplish this, study must be made of all economic, social, and similar aspects of such care.

5. In order that the above program may be effectively carried out, the Secretary of the Council, with the guidance of the Council in conformity with the above expressed relationships with other Bureaus and Departments, shall inform the profession through the various State organizations of all pending national legislation and bureau directives affecting the practice of medicine. It shall likewise be his duty with the guidance of the Council, to arrange for medical representation at meetings and hearings pertaining to medical care, collaborating in the representation with other Councils and Bureaus of the American Medical Association who have an interest in this same subject.

6. The Secretary is instructed with the supervision of the Council, and in collaboration with the Department of Public Relations, to disseminate information concerning the activities of the Council through the publications of the American Medical Association and the various state medical journals, and to prepare and release information on medical care.

The Council has already issued its Statement of General Policies, and it will act in accordance with those Policies and the above methods of functioning.

## BIRTHS AND DEATHS

### BIRTHS

Dr. and Mrs. James L. Estes of Tampa announce the birth of a son, James L. Estes, Jr., on October 6.

### DEATHS

Dr. J. W. Hood of Ocala died on November 22.

Dr. John A. Herring of St. Petersbрг died on November 17.

## DR. MORTON PRESENTS MONUMENT TO LYNCHBURG

"Vision," "Fortitude" and "Kindliness" are beautifully personified in a three-figure statue presented to "The Sons and Daughters of Our City of the Hills," Lynchburg, Va., by Rosalie Slaughter Morton, M. D., of Winter Park on October 10, 1943. It is the work of Brenda Putnam, sculptress. In her address of presentation, Dr. Morton described the qualities expressed by the figures as follows:

"Vision," it seems to me, is the ability to choose between various values those which are the most forceful, far reaching and beneficial to humanity. Spiritual vision is truth, combined with capacity and judgment in arriving at decisions which may be minute or magnificent but which are intrinsically just.

"Fortitude" represents enduring faith and courage. Her sword is that of the crusader, at home and abroad, throughout the ages. Her strength is sturdiness for all valiant and noble causes. She not only hopes, but fights, in her own brave way, for what is right.

"Kindliness" is filled with understanding and sympathy. The dove of peace, with its broken wing, has sought her help. Her wide-set, thoughtful eyes look beyond the immediate, searching the causes and results of cruelty, suffering and sin. She is tireless in her gentle determination to solve and remedy the ills which retard our progress toward health of mind and body. She has a vital part in the evolution of generosity of thought, which is necessary to harmonize constructively all the factors of life.

The inspiration, which it is my hope that this monument will give to all who are bewildered or who have suffered, is that their minds may be lifted above grief and all earthly limitations . . .

This gift represents thousands of hours of service devoted to humanity, and the ideals of a life time. To you I give my best, because I remember tenderly my happy childhood and girlhood here, and your loving kindness to me when I have returned from time to time during the later years.

## STATE NEWS ITEMS

All members desiring to read papers at the Association's annual convention in April are requested to contact immediately Dr. Herbert E. White, Box 1018, Jacksonville 1. There are five or six places open on the scientific program for members, and the Association's Committee on Scientific Work will make assignments not later than January 31. If you desire a place on the program it is, therefore, important that application be made without delay.

Dr. E. C. Crouch of Jasper attended the Graduate Fortnight of the New York Academy of Medicine in New York City in October.

Dr. S. B. Forbes of Tampa returned the latter part of November from a six-weeks' trip to Chicago and New York. While in New York he completed Dr. James White's course in ocular muscles and Dr. Rudolf Aebil's course in ocular surgery.



The Scientific Exhibit at the Chicago Session of the American Medical Association, June 12-16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences with particular emphasis on graduate medical instruction for the physician in general practice.

Application blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.



Dr. Harry C. Galey of Key West was appointed city health officer on November 17.



Florida's Statewide Venereal Disease Steering Committee, consisting of representatives of Army, Navy, welfare, health, and law enforcement groups met recently with officials of the State Board of Health to prepare a statewide educational campaign against venereal disease. Dr. R. F. Sondag, chairman, said: "We have been too timid in presenting facts to the public." Major Onis G. Hazel, Third Air Force, pledged cooperation of every Army field and camp and stated that the story of how to prevent infection or where to go for treatment must be told and retold in places where it will reach the most sought clientele and in the language of that clientele. The campaign for mass education will be carried by billboards, newspapers, radio, and a dozen less prominent but just as effective channels designed to reach some groups more in need of help than others.



Dr. T. E. Cato of Miami, director of the Dade County Health Unit, was the principal speaker at a school health meeting of the Homestead P.-T. A., Wednesday, November 17.

Dr. John H. Mitchell of Jacksonville was the guest speaker at the local Exchange Club's luncheon meeting on December 1. His subject was "Juvenile Delinquency."



The next examinations of the American Board of Ophthalmology will be held in New York City in June and in Chicago in October. Applications for the June examination should be filed no later than December 15, 1943, and for the October examination, no later than April 1, 1944. All applications received after January 1, 1944 will be subject to the increased total fee of \$75.00. Applications should be mailed to 6830 Waterman Avenue, St. Louis, Mo.



Members of the Association who attended the American College of Physicians' Course in Special Medicine, held in Philadelphia, November 8-19, were Drs. Louie Limbaugh and J. Webster Merritt of Jacksonville.



Attending the meeting of the Inter-State Post-graduate Medical Association in Chicago, October 26-29, were the following Florida doctors: J. S. Turberville, Century; W. C. Young, Chiefland; Lawrence L. Stepp, Ft. Lauderdale; Kenneth A. Morris, Jacksonville; J. Raymond Graves, Laura M. Hobbs, Young C. Lott, Miami; Frank D. Gray, C. J. Larsen, Duncan McEwan, Orlando; Arthur J. Bieker, St. Petersburg; S. W. Fleming, West Palm Beach.



At the meeting of the Southern Medical Association in Cincinnati, November 16-18, the following Florida members were in attendance: T. C. Kenaston, Cocoa; Andre A. Cueto, Ft. Lauderdale; William C. Thomas, Gainesville; Henry Hanson, Luther W. Holloway, Gordon H. Ira, Robert B. McIver, Jacksonville; D. A. McKinnon, Marianna; M. Jay Flipse, Walter C. Jones, E. Sterling Nichol, Miami; Jack J. Falk, Miami Beach; Eugene G. Peek, Ocala; Carol C. Webb, Pensacola; Arnold S. Anderson, St. Petersburg; George H. Putnam, Sanford; Terry Bird, Tallahassee; Lloyd J. Netto, Harry A. Wakefield, West Palm Beach.

### JAMES DENHAM PASCO

Dr. James D. Pasco of Jacksonville died following a long illness, on November 12.

Born in Monticello, Florida, in 1883, he was the son of the late United States Senator Samuel Pasco and Jessie Denham Pasco. He received his collegiate education at Hampden-Sidney College and his medical training at the University of Virginia, from which he was graduated in 1906. After serving his internship at the Protestant Hospital in Norfolk, he became resident physician at the Polyclinic Hospital, New York City.

He entered private practice in Jacksonville in 1910, which he continued until his last illness. He had a large practice, and was beloved both by his patients and his fellow members of the medical profession. He was active both in his county society and in the State Medical Association.

Dr. Pasco was a major in the medical corps during the first world war and on active duty for its duration.

He was prominent in religious circles and was a senior warden of the St. John's Episcopal Church of Jacksonville. His death will be keenly felt throughout the entire community.

Survivors are his widow, Mrs. Dorothy Myers Pasco; a son, U. S. Army Aviation Cadet James D. Pasco, Jr., stationed at San Antonio, Texas; two sisters, Mrs. Elizabeth Tims, Tampa, and Mrs. George Conrad, Harrisonburg, Va., and a brother, John Pasco, of Raleigh, N. C.

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### JAMES RAGAN McEACHERN

Dr. J. R. McEachern, health officer of Tampa for twelve years and director of the new City-County Consolidated Health Unit which he helped organize, died on November 1 at the age of 70 years.

Dr. McEachern, known to thousands of Tampanians, was born in Cleburne County, Ala., and moved to Georgia with his family when a child. He was graduated from the Graham Male and Female College and studied medicine for two years at the University of Alabama. He completed his course at the College of Physicians and Surgeons in Atlanta in 1902, and practiced medicine at Bremen, Ga., until 1904, when he moved to Monticello. There he practiced until 1917.

He served as a member of the Florida Senate from the 22nd District during the legislative

sessions of 1915 and 1917. He also was a member of the City Council in Monticello.

Entering the United States Army as a first lieutenant in the Medical Corps, Dr. McEachern advanced to the rank of major during World War I.

Following the war he came to Tampa to live and built up a large medical practice in the years before his appointment as City Health Officer by Mayor Chancey in November, 1931.

Dr. McEachern was a Mason, Odd Fellow, member of the Knights of Pythias, American Medical Association, life member of the Florida Medical Association, American Public Health Association, the Hillsborough County Medical Society, past president of the Civitan Club and a member of the U. S. S. Tampa Post, American Legion. He was a member of the First Baptist Church.

Dr. McEachern is survived by his widow, Mrs. Lilla C. McEachern; his father, A. D. McEachern; two brothers, W. D. McEachern and Archie McEachern, Birmingham, Ala., and two sisters, Mrs. Jack Philpot, Buchanan, Ga., and Mrs. Mattie Nelson, Stepville, Ala.

#### JOHN AUGUSTUS HERRING

Dr. John A. Herring, a resident of St. Petersburg since 1925, died on November 17, at the age of 52. He had been active and prominent in medical circles as well as in the civic and fraternal life of the city. He had been a director of Florida Military Academy since 1932 and also served as post physician for that institution. He was medical director of draft board No. 2, a member of the Pinellas County Medical Society, the Florida Medical Association, and the American Medical Association. Dr. Herring was president of the Pinellas County Medical Society in 1940.

He was a member of St. Petersburg lodge No. 139, F. & A. M.; Sunshine Commandry No. 21, Knights Templar, and Oriental Temple Shrine at Troy, N. Y. He was a Scottish Rite Mason, belonging to the Albany Consistory, a member of the local Rotary Club, the Yacht Club, Lakewood County Club, and St. Peter's Episcopal Church. He was also associated with Nu Sigma Nu honorary medical fraternity, and the Kappa Alpha and Sigma Xi fraternities.

Dr. Herring was married to Evelyn Dulin, who survives him, in 1923, two years before he

came to St. Petersburg from Lexington, Ky., to make his home and practice medicine.

After receiving an A.B. degree at Georgetown College at Georgetown, Ky., Dr. Herring received his medical degree in 1916 from the University of Michigan Medical School at Ann Arbor. He then went to St. Luke's Hospital in New York City, for his internship, after which he served for three years on the staff of Mt. McGregor Sanitarium of the Metropolitan Life Insurance Company at Mt. McGregor, N. Y.

Before going into practice for himself, he taught anatomy at Cornell University for a year and was an instructor at the University of Michigan Medical School for a similar period. He studied roentgenology at the latter institution.

Three years prior to coming to St. Petersburg, Dr. Herring practiced medicine with his brother, Dr. Harry T. Herring, in Lexington. At the time of his death, he was a staff member of St. Anthony's and Mound Park hospitals and was head of the x-ray department at St. Anthony's.

In addition to his wife, survivors are a son, John Augustus Herring II; a daughter, Evelyn Rosetta Herring; two brothers, George L. Herring, Georgetown, Ky., and Dr. Harry T. Herring, Lexington.

#### COMPONENT COUNTY SOCIETIES

##### DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

The members of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society held a meeting in Wauchula on Tuesday evening, November 9, beginning with a dinner at Fowler's Cafe. Dr. Wesley W. Wilson of Tampa was principal speaker, presenting a paper on "Common Fungus Diseases of the Skin," illustrated with slides. Lt. Waisman, dermatologist at Drew Field base hospital at Tampa, and Capt. M. B. White, chief of the laboratory section at MacDill Field base hospital, Tampa, led in the discussion.

A business meeting was then held, during which the following officers were reelected for 1944: president, Dr. M. C. Kayton of Wauchula; secretary-treasurer, Dr. C. H. Kirkpatrick of Arcadia.

## PASCO-HERNANDO-CITRUS

Dr. W. B. Moon of Crystal River was host to the members of the Pasco-Hernando-Citrus County Medical Society at an oyster and fish dinner served at the Magnolia Lodge on the evening of November 11.

At a business meeting which followed the dinner, a discussion was held on Senate bill 1161, and letters were read from state senators and representatives, which were in reply to inquiries sent in by the society.

Drs. Claude L. Carter of Inverness, G. R. Creekmore of Brooksville, S. C. Harvard of Brooksville, W. Wardlaw Jones of Dade City, and William H. Walters of Lacochee, reported interesting clinical cases which were discussed by all present.

## PINELLAS

On November 5 the members of the Pinellas County Medical Society held a meeting at the Veterans' Administration Facility at Bay Pines. The program was arranged by the members of the hospital staff. On November 19 a round table assembly was held at the home of Dr. Elmer B. Campbell, who acted as moderator.

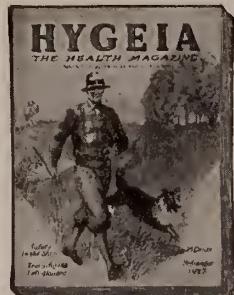
## POLK

At the regular meeting of the Polk County Medical Society, held December 8, the following officers were elected for 1944: president, Dr. W. F. Peacock; vice president, Dr. J. G. Gilchrist; secretary-treasurer, Dr. Edgar Watson. Dr. S. A. Clark was elected censor for a three-year term. Delegates elected to represent the society at the next annual convention of the State Association were: Drs. J. R. Boulware, Herman Watson, and R. H. Mooty; alternate delegates: Drs. W. T. Simpson, Edgar Watson and W. F. Peacock.

Sterling V. Mead, D.D.S., M.S., B.S., guest speaker, delivered an interesting talk on "Diseases of the Mouth." Dr. Mead is Professor of Oral Surgery and Diseases of the Mouth and Director of Research at the Georgetown University Dental School; Professor of Diseases of the Mouth, Georgetown University Medical School; Oral Surgeon to Georgetown Hospital; Chief of Dental Service, Providence Hospital; Dental Surgeon to Gallinger Municipal Hospital; and Consulting Oral Surgeon Casualty Hospital and Freeman Hospital.

## ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN

The members of the St. Lucie-Okeechobee-Indian River-Martin County Medical Society were guests of the USNAT chapter of the Academy of Military Surgeons at a meeting held on the evening of November 4 at the New Burtton Hotel, Ft. Pierce. Comdr. Duemling, base senior medical officer, was chairman; the program was in charge of Lieut. F. J. Faux. The topic for discussion was "Compound and Simple Fractures."



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## ADVERTISERS' NOTES

### SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

Vitamin D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startling high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park\* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5 per cent.

Rachitic changes are present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

\*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child., 66: 11, July 1943.



### MONOGRAPH ON LYMPHOGRANULOMA VENEREUM

Noteworthy contributions to the detection and differential diagnosis of lymphogranuloma venereum are those of Rake, McKee and Shaffer, who have cultivated the agent in the yolk sac of the embryonated chicken's egg and obtained concentrated suspensions of elementary bodies. In this manner a highly purified and specific antigen, known as Lygramum S. T. has been prepared which is rapidly supplanting antigens prepared from either human pus or mouse brain. These workers alone, and in collaboration with Dr. A. W. Grace, have used the yolk sac antigen for the complement-fixation testing of serum suspectedly infected patients. The specificity and sensitivity of this antigen (Lygramum C. F.) provides an additional means of detecting early cases of lymphogranuloma venereum.

In the course of investigations involving these tests, there accumulated at the Squibb Institute for Medical Research a considerable mass of information concerning the properties of the causative agent, the epidemiology and clinical aspects of the disease. To facilitate the work of investigators and teachers in this field, and perhaps to encourage the interest of potential investigators, practicing physicians and health officers, it was decided to compile and publish the information at hand. The result is a 32-page publication entitled Lymphogranuloma Venereum—a Monograph. The value of the book is enhanced by maps, charts and numerous illustrations in color.

The Monograph is available gratis to physicians and to public health officials, and will be a valuable addition to medical college libraries. Those who request copies should enclose their professional card or use their professional letterhead.



### AO'S GLARELESS GLASS

A picture story featuring American Optical Company's latest scientific development—a discovery for removing light reflections from glass and other materials—appeared in the Nov. 22 issue of Life Magazine.

Photographed several weeks ago at the AO plant by Bernard Hoffman, famed Life Magazine cameraman, the story is unusual in view of the large space and number of pictures devoted to the development. The discovery was made by H. R. Moulton, AO's asst. research director, and is restricted to military uses for the duration.

Headlined by the title, "Glareless Glass—New Method checks reflections and increases transparency," the story



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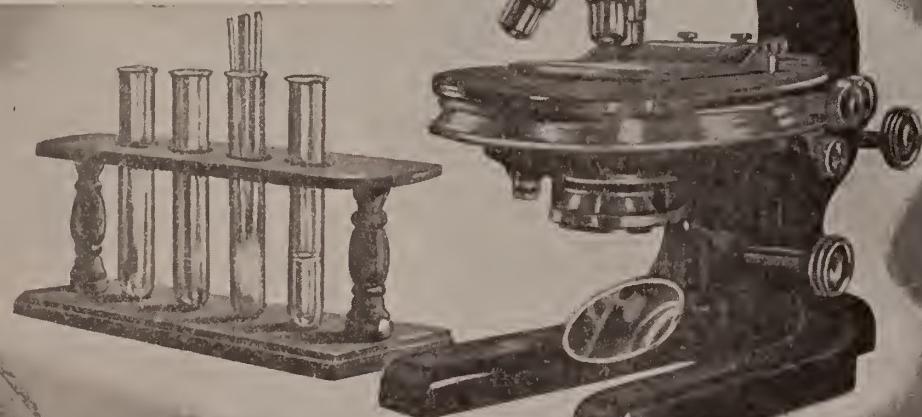
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covers one full page and two half pages. The copy reads as follows:

Almost one-tenth of the light which strikes against an ordinary windowpane never gets all the way through the glass. It penetrates part way, then is reflected back to the outside surface of the pane where it escapes as glare. After 10 years of research, Harold R. Moulton of the American Optical Company, Southbridge, Mass., has developed a new surfacing technique which controls most of the reflected light. By thus eliminating the glare, Mr. Moulton's method can actually increase the light-transmitting capacity of the windowpane.

In contrast to the previous glare-eliminating techniques, Mr. Moulton's method is applicable to many kinds of surfaces. It can, moreover, be used on large surfaces. Previous techniques have been practicable only for small areas. Mr. Moulton feels his development will be used to kill almost all reflections from postwar windshields, windows and spectacle lenses.

The article contains 11 pictures which demonstrate the removal of light reflections or glare from a piece of optical glass, spectacle lenses, an oil painting, auto windshield and glass paperweight. Inventor Moulton is shown at the left in the picture portraying the removal of glare from an auto windshield, and Mrs. Ruth Martel, AO employee, posed for the picture showing the removal of light reflections from spectacle lenses.

Life photographer Hoffman has covered many important news and science stories in recent years. One of his most spectacular accomplishments was the sequence of pictures on skip bombing, which appeared in Life's Nov. 15 issue. He is scheduled to leave in a short time for a picture assignment in the Orient where his bases of operations will be New Delhi and Chungking.



#### UPJOHN COMPANY EXECUTIVE CHANGES

Executive changes in the Upjohn Company which are to become effective the first of the year will bring Donald S. Gilmore to the presidency, a position occupied by Dr. L. N. Upjohn since 1930.

Dr. Upjohn will assume the chairmanship of the board of directors, maintaining his active connection and his general supervision of the company's affairs. The changes were made at a special meeting of the board of directors on November 15.

In addition to the change in the presidency of the concern, the board elevated three men long identified with the executive direction of its affairs to vice presidencies, effective immediately.

Dr. E. Gifford Upjohn, who has been with the company since 1931 and is now medical director, will retain his present duties as medical director in the post of vice president. Dr. Harold S. Adams, who joined the company in 1926 and has been general superintendent, is vice president and director of production.

The third man elevated to a vice presidency is C. V. Patterson, a general sales manager. Mr. Patterson, also placed on the board of directors, now assumes the office of director of sales.

At the same meeting the board named Emil H. Schellack, who with Mr. Patterson has been a general sales manager, the general sales manager of the company. Other officers of the company are John S. McColl, vice president and treasurer; Dr. F. W. Heyl, vice president and director of research; and J. B. Vanderberg, secretary.

Dr. L. N. Upjohn has been with the company since 1904, and was for 25 years head of the New York office. In 1930 he was elected president and took over the actual work of the office when he returned to Kalamazoo in 1931, when Dr. W. E. Upjohn, president and founder of the company, assumed the post of chairman of the board of directors.

Mr. Gilmore joined the Upjohn Company in 1930, and in 1936 was made vice president and later general manager, retaining his position of vice president.

Mr. Patterson and Mr. Schellack both came to the company from Missouri, the former in 1925 as a salesman and the latter in the same capacity in 1923. In 1931 Mr. Patterson came to Kalamazoo as secretary to the late Malcolm Galbraith, director of sales. Mr. Schellack came to the city in 1923 as Kalamazoo branch sales manager. In 1942 upon the death of Mr. Galbraith the two men took over a joint office as general sales managers.

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**OBSTETRICS**—Two Weeks Intensive Course starting February 21st.

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Excerpts from the Bulletin of the Woman's Auxiliary to the American Medical Association are worthy of recognition in our column at this time; we hope that every auxiliary member will take time to read the Bulletin.

**HYGEIA CONTEST**

Mrs. Arthur I. Edison, National Hygeia Chairman, makes the following announcement:

The Auxiliary Hygeia contest for 1943-44, which began September 1, 1943, will close January 31, 1944. The sum of \$400 will be given in cash prizes to the auxiliaries securing the largest number of subscription credits to Hygeia.

Mrs. F. W. Krueger, state president, urges every county Hygeia chairman to work hard to increase the subscriptions to the magazine and get them in to National before the contest is over so that we may become eligible for one of the prizes. Certainly we want the auxiliaries of our state to continue to be an asset to the national organization by maintaining the highest standard which we are capable of achieving.

Many auxiliary women have left their homes to be near their husbands who are in service. If any members of your auxiliary have moved, will you please send their names and new addresses to Mrs. Eben J. Carey, 6119 Wisconsin Ave., Wauwatosa, Wis. By this means they can receive the Bulletin and keep in touch with the auxiliary and its work. Also local auxiliaries can find the names of members who are temporarily in their vicinity and show them courtesies.

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## RESOLUTION AND PLEDGE

The following resolution was adopted at the last meeting of the National Organization, and should be read before every county auxiliary:

## LOYALTY RESOLUTION

WHEREAS, The Woman's Auxiliary to the American Medical Association is worthy of the unfailing loyalty of all of its members; therefore be it

RESOLVED, That the following pledge be adopted and taken by the Woman's Auxiliary at this, the twenty-first annual meeting, and renewed at each annual meeting hereafter; and be it further

RESOLVED, That it be suggested to all State Auxiliaries that they adopt and take said pledge at their next annual meeting and renew it at each consecutive meeting.

## PLEDGE

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

BLOOD SUPPLY OF THE VISUAL PATHWAY. By Calvin M. Kershner, A.B., M.D., Brookings, S. D. Because of the nature of the subject material this book is not likely to become obsolete. It is of interest and value to an-

atomists, physiologists, psychiatrists, ophthalmologists, neurologists and neuro-surgeons in particular—the general practitioner as well—an aid in accurate diagnosis. The clinical side of pathological lesions and their significance is constantly kept in mind and referred to throughout the book. It is adequately illustrated, conveniently arranged and indexed. Cloth. Price, \$3.00. Pp. 160, with illustrations. Boston: Meador Publishing Company, 1943.

ELEMENTS OF MEDICAL MYCOLOGY. By Jacob Hyams Swartz, M.D., Assistant Professor of Dermatology, Harvard Medical School, Boston. Introduction by Fred D. Weidman, M.D., Professor of Dermatological Research, University of Pennsylvania. Cloth. Price, \$4.50. Pp. 190, with 80 illustrations. New York: Grune & Stratton, Inc., 1943.

SURGICAL ERRORS AND SAFEGUARDS. By Max Thorek, M.D., LL.D., D.C.M., F.I.C.S., Professor of Surgery, Cook County Graduate School of Medicine, Chicago. This book is one of the postgraduate influences which has a particular and timely educational value for the surgeon who is about to assume responsible surgical practice. Spread out before him in this work is a field of surgical clinical research. The author records his own errors and those of other surgeons that he has been able to collect, and discusses methods of foreseeing and avoiding these errors. He gives warning of where danger points may be expected in surgical procedures, exposes weaknesses in diagnosis, and describes numerous other surgical experiences collected from his life work. Part of this book deals with certain features of medical jurisprudence without the knowledge of which a surgeon may experience many an anxiety. Fabrikoid. Price, \$15.00. Pp. 1085, with illustrations. Philadelphia: J. B. Lippincott Company, 1943.

## SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association .....	Eugene G. Peek, Ocala.....	Shaler Richardson, Jacksonville.....	St. Petersburg, Apr. 13-14, 1944
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville....	" " "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach....	" " "	Miami, Postponed
American Medical Association .....	James E. Paullin, Atlanta, Ga.....	Olin West, Chicago .....	Chicago, June 12-16, 1944
Southern Medical Association .....	W. T. Wootton, Hot Spgs, Ark.....	Mr. C. P. Loranz, Birmingham.....	November, 1944
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery .....	Montgomery, Apr. 18-20, 1944
Georgia, Medical Assn. of .....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	Savannah, May 9-12, 1944
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg....	Kenneth Phillips, Miami.....	To Be Announced
Basic Science Exam. Board .....	M. W. Emmel, D.V.M., Gainesville	J. F. Conn, Ph.D., DeLand .....	Gainesville, June 8, 1944
Dental Society, State.....	E. C. Lunsford, D.D.S., Miami .....	H. L. Cartee, D.D.S., Miami.....	
Derm. and Syph., Soc. of .....	Wiley M. Sams, Miami .....	Lauren M. Sompayrac, Jacksonville .....	
East Coast Medical Association .....	T. C. Kenaston, Cocoa .....	I. M. Hay, Melbourne .....	
Hospital Association .....	Mr. W. E. Arnold, Jacksonville .....	Miss Katharine Moyer, Lake Wales .....	
Industrial Surgeons, Assn. of .....	Frank D. Gray, Orlando .....	Frank T. Barker, Tampa .....	
Medical Examining Board .....	I. W. Chandler, Avon Park .....	W. M. Rowlett, Tampa .....	
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville .....	Chairman .....	
Nurses Association, State .....	Miss Florence Jones, Jacksonville .....	Miss Madalee Hazel, Limona .....	
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville .....	C. E. Dunaway, Miami .....	To Be Announced
Pathological Society .....	L. Y. Dyrenforth, Jacksonville .....	Iva C. Youmans, Miami .....	To Be Announced
Pediatric Society .....	Ludo von Meysenbug, Daytona B.	Robert Blessing, Ft. Lauderdale .....	To Be Announced
Pharmaceutical Association, State .....	Mr. H. B. Douglas, Bonifay .....	Mr. R. Q. Richards, Ft. Myers .....	Miami, To Be Announced
Public Health Association .....	Leland H. Dame, Sanford .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	John N. Moore, Ocala .....	Walter A. Weed, Orlando .....	
Railway Surgeons' Association .....	Frank D. Gray, Orlando .....	W. C. Page, Cocoa .....	
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales .....	Mrs. May Pynchon, Jacksonville .....	
Chattahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine .....	Robert B. McIver, Jacksonville .....	
Gulf Coast Clinical Society.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola .....	Kenneth Phillips, Miami .....	
Southeastern Surgical Congress .....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta .....	
Suwannee River Medical Society .....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City .....	

**COMPONENT SOCIETIES BY DISTRICTS**

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	J. Powell Adams, M.D. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		13	12	A-1-45 C. D. Whitaker, M.D. Marianna
Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	48	100%	
Franklin-Gulf		J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	5	100%	
Jackson *Calhoun	R. N. Joyner, M.D. Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	100%	
Walton-Okalooosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	6	100%	
A Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	100%	
Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	James W. Sapp, M.D. Havana	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 8:00 P.M.	40	100%	
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		7	100%	
Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	G. H. Warren, M.D. Perry	Last Friday 8:00 P.M.	5	4	
A Alachua *Bradford, Gilchrist, Union	Geo. C. Tillman, M.D. 505 W. University Gainesville	Chester F. Ahmann, M.D. 1043 W. Masonic Gainesville	2nd Wednesday 7:30 P.M.	28	26	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
Duval *Clay	T. Z. Cason, M.D. 2033 Riverside Ave. Jacksonville, 4	F. A. Copp, M.D. 411 St. James Bldg. Jacksonville 2	1st Tuesday 8:15 P.M.	194	193	
Marion *Levy	T. Hartley Davis, M.D. 202 Commercial Bk. Bldg. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	28	27	
Nassau	Geo. A. Dame, M.D. Fernandina	E. F. Waite, M.D. Fernandina	2nd Wednesday 8:00 P.M.	9	100%	
Putnam	J. Worth Brantley, M.D. Grandin	C. M. Knight, M.D. Palatka	2nd Tuesday Even Months 7:00 P.M.	9	100%	
St. Johns	Alfred W. Norris, M.D. Flagler Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	G. E. Christie, M.D. Box 151 Titusville	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	100%	
Lake *Sumter	Louis R. Bowen, M.D. Eustis	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	100%	
Orange *Osceola	T. E. McBride, M.D. Apopka	John A. Pines, M.D. 106 E. Central Ave. Orlando	3rd Wednesday 8:00 P.M.	90	85	
Seminole	Geo. H. Putnam, M.D. Touchton Bldg. Sanford	Leland II. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	13	100%	
Volusia *Flagler	L. von Meysenhung, M.D. Box 3356 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	43	100%	
Hillsborough	T. C. Maguire, M.D. 104 S. Collins St. Plant City	Curtis B. Jefferson, M.D. 818 First Nat. Bk. Bldg. Tampa 2	1st Tuesday 8:00 P.M.	105	99	C-5-44 Leland F. Carlton, M.D. Tampa
Manatee	M. M. Harrison, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	14	100%	
Pasco-Hernando- Citrus	W. W. Jones M.D. Dade City	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	11	100%	
Pinellas	J. A. Hardenbergh, M.D. 404 Power & Light Bldg. St. Petersburg 4	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg 4	1st and 3rd Fridays 6:30 P.M.	104	103	
Sarasota	O. H. Cribbins, M.D. 138 N. Link Sarasota	A. O. Morton, M.D. Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	19	100%	
DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	100%	
Lee *Collier, Hendry	H. Quillian Jones, M.D. 18 Leon Bldg. Fort Myers	W. H. Grace, M.D. Box 907 Fort Myers	3rd Tuesday 7:30 P.M.	17	100%	
Polk	T. G. Simmons, M.D. Corlett Bldg. Auburndale	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	63	100%	
Palm Beach	K. Montgomery, M.D. Guaranty Bldg. W. Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	4th Monday 8:00 P.M.	68	64	D-7-45 William Y. Sayad, M.D. West Palm Beach
St. Lucie- Okeechobee-Indian River-Martin	Francis A. Gowdy, M.D. Box 745 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	100%	
Broward	D. W. Harris, M.D. 420 Sweet Bldg. Ft. Lauderdale	O. C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	2nd Wednesday 8:00 P.M.	41	100%	
Dade	H. L. Pearson, M.D. 416 Ingraham Bldg. Miami	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami	1st Tuesday 8:30 P.M.	347	341	D-8-44 Elbert McLaury, M.D. Hollywood
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P.M.	5	100%	

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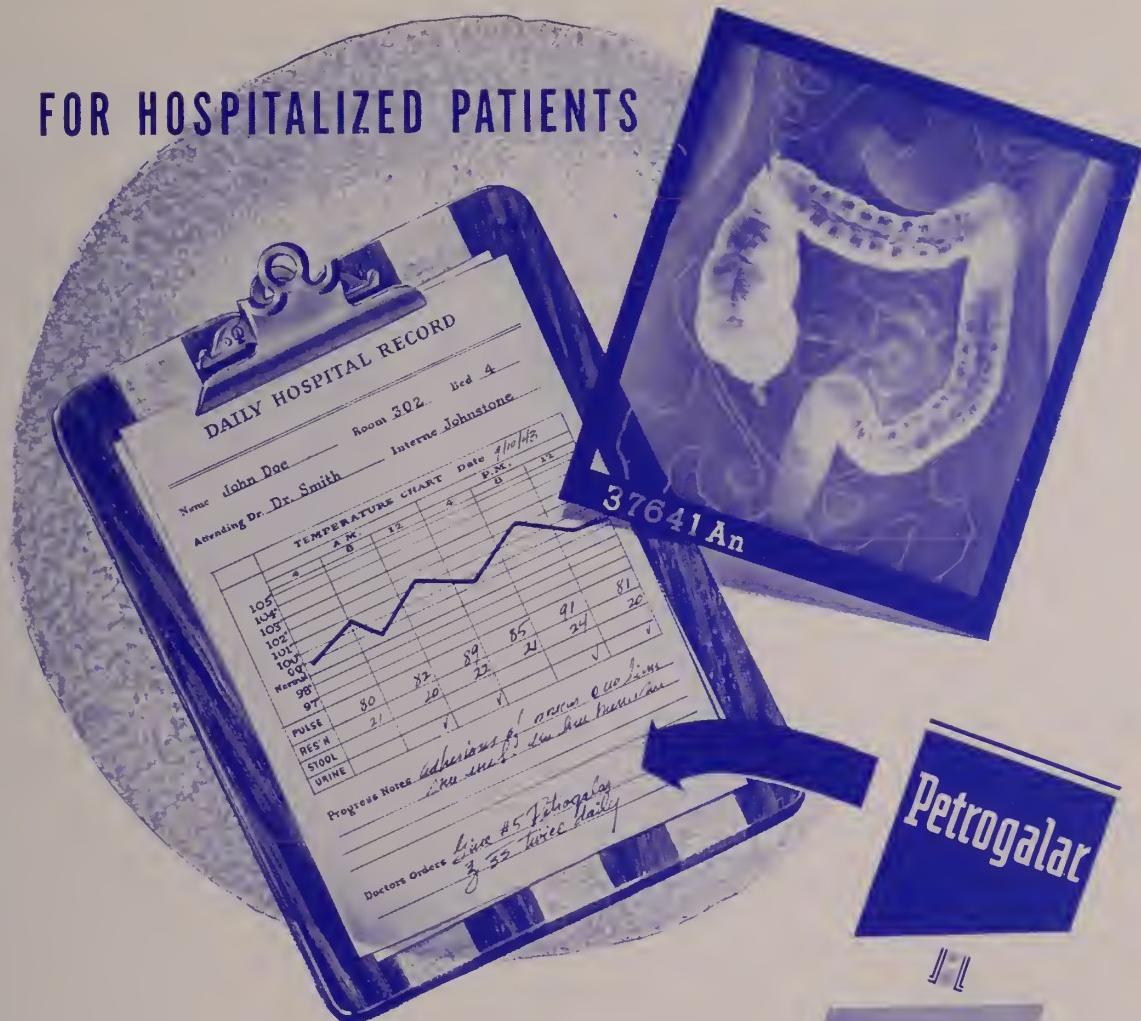
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Vol. XXX

FEBRUARY, 1944

No. 8

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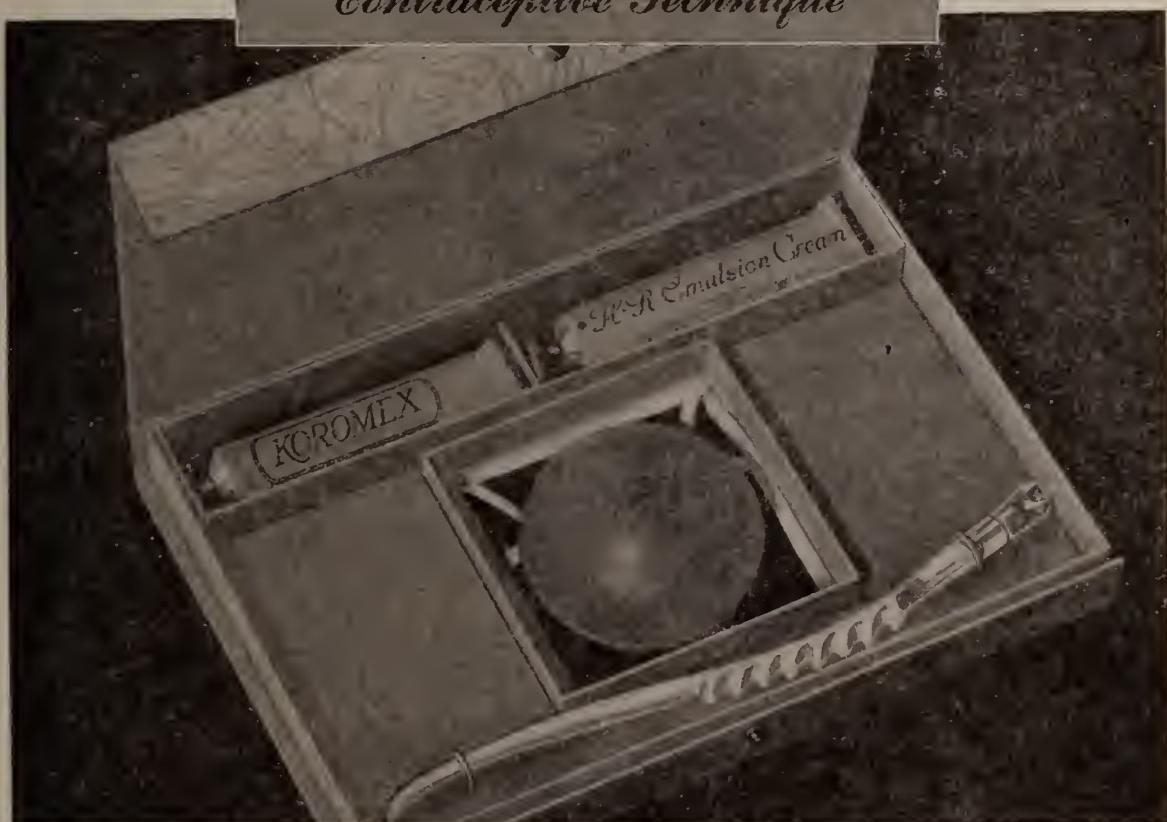
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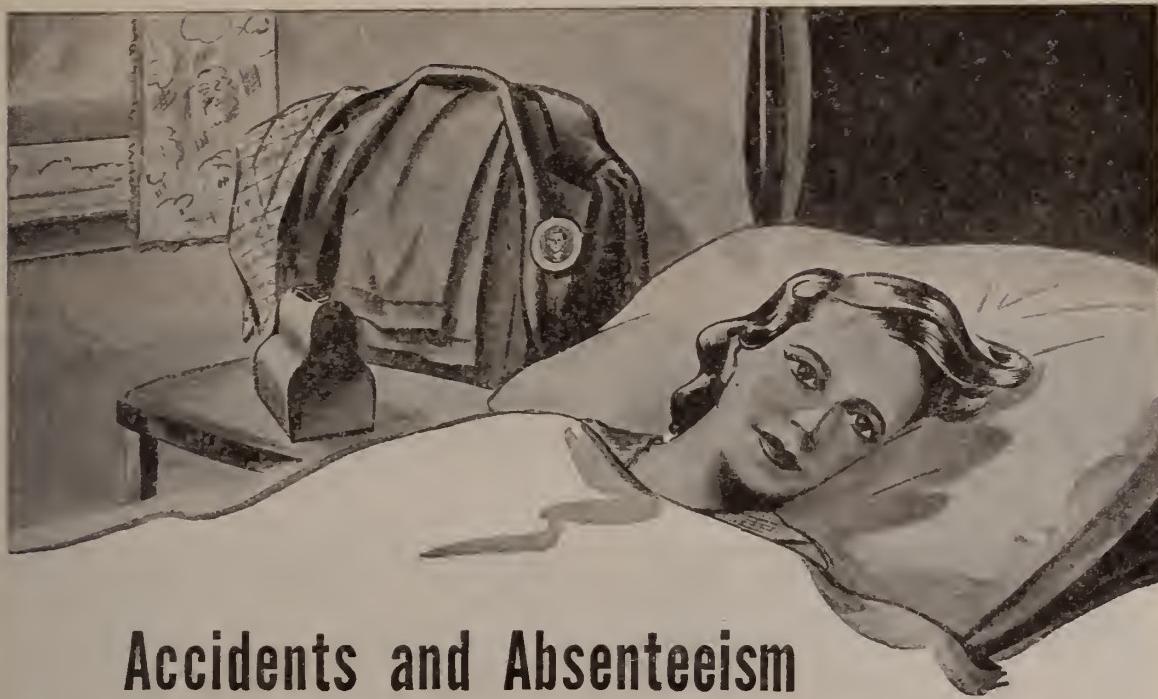
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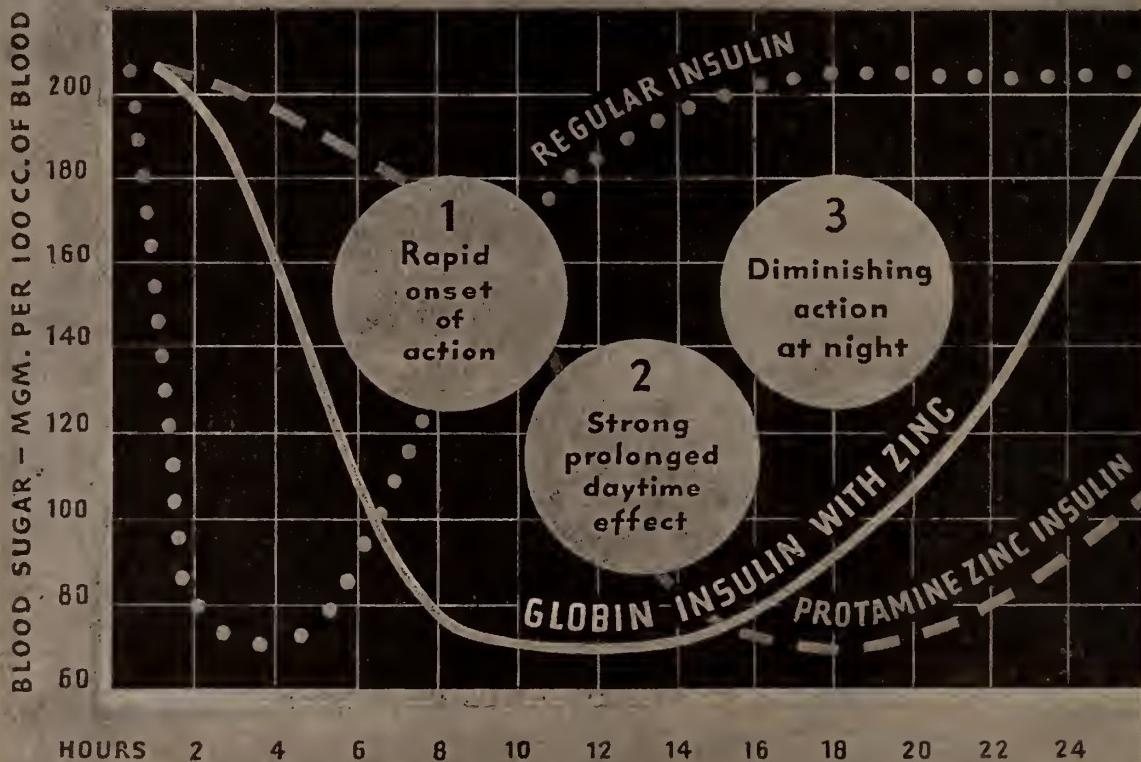
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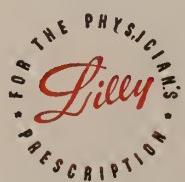
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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No. 8

## EWING'S TUMOR OF THE TEMPORAL BONE

REPORT OF A CASE

S. B. FORBES, M. D.  
TAMPA

While Ewing<sup>1a</sup> was not the first to describe endothelial tumors, it was he who first separated these growths into a fairly distinct clinical and roentgenologic group. He adopted the conception of Borst<sup>1b</sup> that the scope of endotheliomas is probably wide, and selected a nonosteogenic tumor of bone with many clearcut clinical features which he classified as endothelial myeloma or diffuse endothelioma.<sup>1c</sup> Since his report was published in 1922, investigation of endothelial myeloma, or Ewing's tumor, has been stimulated, and this type of malignant growth has been more readily recognized because of its peculiar clinical behavior and its reaction to irradiation.

In a review of malignant tumors of bone Meyerding<sup>2a,c</sup> reported that Ewing's tumor occurred in 26.9 per cent of the cases; he added that this disease was diagnosed in 1 patient out of every 7,666 who registered at the Mayo Clinic. Approximately 15 per cent of the 650 sarcomas of bone of all types in the Surgical Pathological Laboratory of the Johns Hopkins Hospital were classified as Ewing's sarcoma, and their incidence in men predominated by about 2 to 1. Only 1 case represented in this collection occurred in a Negro. The disease is apparently rare in all races except the Caucasian.<sup>3a</sup>

Ewing's tumor is predominantly a disease of early life. The cause is unknown. Theories as to its origin include those of chemical or hormonal embryogenic disturbance, infection and trauma; also, as Hamilton<sup>4</sup> observed, the disease may have a multiple primary origin. Trauma is apparently of some etiologic significance. In the cases in which it was recorded in the series of Geschickter and Copeland,<sup>3a</sup> it was definitely related to the subsequent onset of the clinical symptoms; the average lapse of time between trauma and symptoms was five and one-half months, the extremes being a few days and more than a year. These authors were of the opinion that in the majority

of these cases the injury probably served as the stimulus for the malignant growth instead of being superimposed on an already existent tumor. In 35.1 per cent of the series of cases reported by Meyerding<sup>2a,c</sup> a positive history of trauma was given.

The shaft of the long bones is the most frequent site of this tumor, and of all the bones involved, the femur and the tibia appear to be most commonly affected. This disease, however, never primarily involves an epiphysis. The involvement of a single bone early in the disease with later dissemination to other bones is a striking and important feature that distinguishes Ewing's tumor from other tumors of bone. The most frequent sites of metastasis are the lungs, the skull and the lymph nodes.

While the skull may be affected secondarily by benign and malignant conditions arising in other organs, new growths originating in the cranial bones are observed infrequently. The occurrence of Ewing's sarcoma primarily in these bones is truly rare, and its presence in the temporal bone is extremely rare, especially in children under 4 years of age.<sup>3a,b</sup> In their recent report of a case of endothelioma of the mastoid Scal and Ide<sup>5</sup> cited New<sup>6</sup> as stating that it was observed only twice among 40,000 patients admitted to the otolaryngologic department of the University of Michigan. They noted that the youngest patient mentioned in the literature was a 3 year old boy, whose case was reported by Hegener.<sup>7</sup> Their patient was a boy aged 21 months when the diagnosis was established and radiotherapy instituted. Zimmerman,<sup>8</sup> in reporting a case in a child 5 years of age, stated that of the 47 cases of primary sarcoma of the mastoid he found recorded in the literature, only 9 could be classed as Ewing's tumor. In a series of more than 500 cases of primary sarcoma of bone reported by Geschickter,<sup>3a,b</sup> there were only 3 cases of this disease, 2 of them in children with the mastoid process involved.

This tumor grows insidiously. Pain, the early and outstanding symptom, may be intermittent, but becomes increasingly severe and prolonged as the condition progresses. Pain and tumor, and not infrequently trauma, as a rule form the syndrome. When the disease is pri-

mary in the cranial bones, facial paralysis and severe pain in the region of the mastoid may be the first symptoms; later there may be involvement of the abducens, trigeminal, vagus, glossopharyngeal and hypoglossal nerves with extension to the brain causing hemiplegia.<sup>5</sup> Again, a foul bloody discharge from the external auditory canal may be the first indication of its presence.

With swelling of the affected part, local tenderness to pressure and an elevated local temperature of the skin may occur. The body temperature may vary from 99 to 103 F. Leukocytosis may be observed early in the course of the disease as well as following metastasis. A mild degree of secondary anemia may be indicated by a low value for hemoglobin and a diminished erythrocyte count. Occasionally there may be an eosinophilia ranging from 4 to 20 per cent. A noticeable loss of weight over a relatively short period of time may occur early in the course of the disease; on the other hand, little or no evidence of undernutrition may be observed until the terminal phases reveal a progressive emaciation.<sup>3\*</sup>

The tendency of Ewing's tumor to destroy bone is evidenced roentgenologically by irregular absorption and the pushing out of the thickened periosteum, in contradistinction to osteomyelitis, which is far less destructive. The onion peel-like formation that characterizes the roentgenogram in the early stages and the other roentgenologic features will be described by Dr. C. M. Gray for Dr. J. C. Dickinson, who treated the patient whose case is herein described and who graciously consented to explain this aspect of the disease.

The typical microscopic appearance is perhaps the most uniform characteristic of this tumor. Dr. H. R. Mills, who established the pathologic diagnosis in this case, has kindly agreed to discuss the gross and microscopic pathology. It is of interest to note in passing that in numerous cases, particularly those of longer duration and those in which the tumor has previously been explored, there may be infiltration of the periphery of the tumor by cells of the polymorphonuclear or monocytic type, a phenomenon that may lead at biopsy to an erroneous diagnosis of osteomyelitis.

As this disease may closely simulate a minor affection, it is essential that diagnosis rest on correlation of all available data. Confirmation by microscopic examination of the clinical and roentgenologic findings is particularly im-

portant. In differential diagnosis, differentiation from osteomyelitis is of great importance. Ewing's tumor is also not infrequently confused with tuberculosis of the bone, syphilitic disease of the bone, multiple myeloma and osteogenic sarcoma. In children under 4 years of age Christian's disease, lymphatic leukemia, or metastases from neuroblastoma of the adrenals may be a source of confusion.

Since Ewing's tumor is usually radiosensitive,<sup>2b</sup> irradiation offers a means of confirmatory diagnosis without recourse to surgery.<sup>2c</sup> Desjardins<sup>2e</sup> maintained that the rapid melting away of this tumor under the influence of irradiation is an even more accurate diagnostic test than is biopsy. Its response to irradiation by roentgen rays or radium is of greater degree than that of any known tumor of bone.<sup>6</sup> Since the roentgen signs result from destructive and reparative processes in osseous tissue any of which may be seen in osteogenic sarcoma, metastatic tumor or non-neoplastic lesions and are therefore not unequivocally characteristic, irradiation as a diagnostic agent is most valuable. Shrinkage of the tumor usually takes place after two or three treatments.

In treatment, surgery and irradiation combined give the best results as they yield about 10 per cent of permanent cures.<sup>3a</sup> In fatal cases the average postoperative duration of life is sixteen months. In addition to providing a good diagnostic test, irradiation offers the best palliative therapy available as it relieves the symptoms and prolongs the life of the patient. Indeed, it is the only remedy that has a beneficial action on the evolutionary process and may alone even effect a few cures, but this form of treatment should not be persisted in longer than six weeks if definite results are not attained. Its transient effect in many cases should be kept in mind. The evidence indicates that radical operation followed by irradiation offers the most hopeful prospect for life. At best, the prognosis is extremely grave.

The report that follows is of necessity preliminary in nature. The ultimate outcome of the case presented is awaited with interest. Although Ewing's tumor is a disease of youth, its occurrence is extremely rare in a child 2 years of age, especially in the form of a primary lesion of the temporal bone, as occurred in this case. Pain and discharge from the external auditory canal were present at the age of 3 months, the earliest at



Fig. 1. Roentgenogram made preoperatively. Note the massive destruction of the left mastoid.

which symptoms have been recorded, and when the child first came under my observation at the age of 2 years, he was subjected to radical excision of the tumor, also at the earliest age recorded in the literature.

#### REPORT OF CASE

J. H., a white boy aged 2, first came for examination on Nov. 10, 1941. The mother related that from the time the child was 3 months old, he had experienced pain in the left ear apparently continuously and also drainage from this ear at times until two months previously when it had begun to drain constantly, with some relief of pain resulting. She was of the opinion that there was no hearing in this ear. Her physician had noted a mass in the external auditory canal and had advised its removal. The boy, her first child, was delivered without the use of instruments, she reported, and was normal at birth. There was no history of trauma, and there had been no illnesses other than the trouble with the ear. The general health of the child was good.

On examination, edema and apparently a defect of bone due to destruction were noted on the left side over the entire mastoid region from the tip to above the external auditory canal. The mastoid was extremely tender. A large mass, pinkish gray in color, was observed pos-

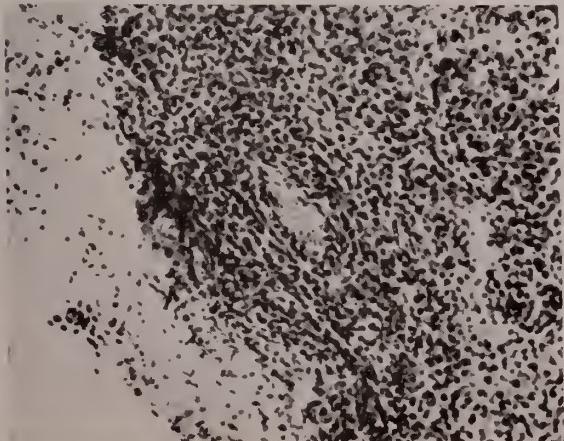


Fig. 2. Low power microscopic view of the tumor.

terosuperiorly in the external auditory canal, and some mucopurulent material was present. It was difficult to determine whether the drum was intact because of the protrusion of the tumor. Examination of the right ear gave negative results.

The patient was admitted to the Tampa Municipal Hospital on November 12. The general physical examination gave normal results. Examination of the blood showed erythrocytes 4,200,000, leukocytes 16,800, polymorphonuclears 59, lymphocytes 40 and monocytes 1; the hemoglobin estimation was 65 per cent, the color index determination was 0.7, and the nuclear index determination was 9. The results of the Kolmer test were negative.

It was impossible to immobilize the patient sufficiently to obtain roentgenograms of satisfactory diagnostic quality as he cried during the whole examination. The report of Dr. A. F. Massaro, the roentgenologist at the hospital, follows: "There is a spectacular area of bone destruction of the left temporal bone with a clouding of the left antrum. Changes are indicative of a left mastoiditis with an extensive cholesteatoma or a large cyst . . . . The possibility of Christian-Schüller disease has to be ruled out." See figure 1.

On the day of admission a mastoidectomy was performed on the left side. The usual incision was made, but the cortex was found to be everywhere only a shell. The extensive area of bone destruction extending through the cortex from the zygomatic region posteriorly to the region of the sinus dural angle and down to the tip, necessitated a posterior extension of the incision from the midpoint. The mastoid was filled with a pinkish gray mass rather resembling but not typical of cholesteatoma, and there were areas of apparent necrosis. The tegmen of the tympanum, mastoid and antrum, and the internal table in Troutman's triangle and posteriorly over the posterior fossa extending well back to the region of the emissary vein had been destroyed. The lateral sinus had also been destroyed as a probe could be passed into the jugular bulb, but posteriorly adhesions between the internal table and the dura had sealed off the sinus, where healthy bone was present. Thus identification of the lumen of the sinus posteriorly was prevented as no attempt was made to open it after the condition was recognized. The dura looked fairly healthy. Through a fistula in the posterior membranous wall a mass of the tumor tissue protruded into the external canal. The destruction of bone extended well forward of the external canal into the zygomatic region.

The operation was extensive, lasting one hour and thirty-five minutes. Bleeding was fairly profuse. The tumor was excised well into healthy bone except toward the petrous portion of the temporal bone where the procedure was extremely difficult. The wound was closed only partially posteriorly.

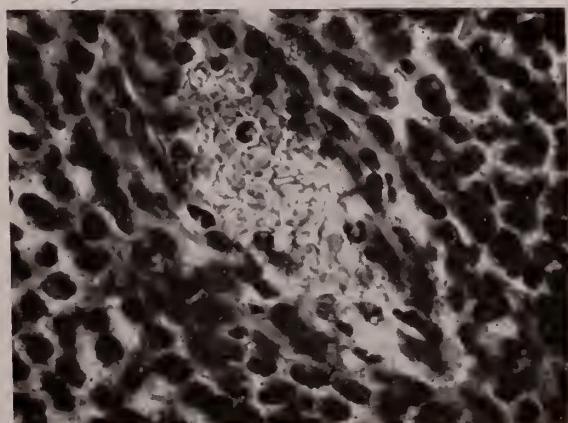
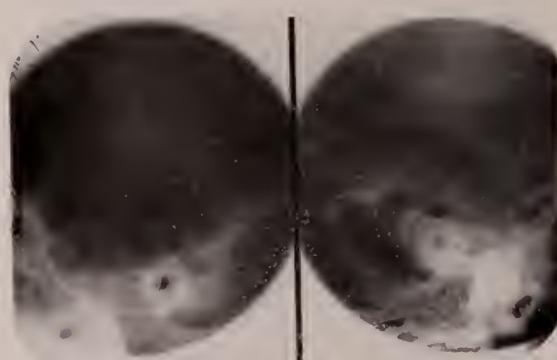


Fig. 3. High power microscopic view of the tumor.

The immediate postoperative course was without untoward incident. The patient was dismissed from the hospital on November 17.

The material obtained at operation for bacteriologic study and the several specimens taken for biopsy were examined by Dr. Mills. The report of the microscopic examination of sections and the pathologic diagnosis follow: "Microscopical sections show a predominance of necrosis scattered throughout which are ill defined islands of cellular tissue. In these cellular areas the cells are small, round or slightly polyhedral and show no intercellular substance. The cells are of remarkably uniform size and morphology. The cytoplasm is mostly indistinct, but in some areas seems to communicate with the adjoining cells by means of a fine network. The cellular areas are quite vascular and often a perithelial arrangement is noted. Mitotic figures are an occasional occurrence. In the necrotic areas particularly a few inflammatory cells are found, including a few plasma cells and phagocytes. Opinion: Diffuse endothelioma of bone (endothelial myeloma, Ewing's tumor)." See figures 2 and 3. The culture from the wound showed no growth.



*Fig. 4. Roentgenogram made nine days after the operation.*

The pathologic diagnosis was confirmed by Drs. A. C. Broders, Malcolm Dockerty and J. W. Kernohan, pathologists of the Mayo Clinic, through the courtesy of Dr. Nelson A. Murray of Tampa, now resident there, who also concurred. Dr. Emmerich von Hamm of the Department of Pathology of the Ohio State University also confirmed the diagnosis of Ewing's tumor. Dr. Tracy B. Mallory of the Harvard Medical School made a diagnosis of "a malignancy, probably a lymphoma."

On November 21, nine days after the operation, roentgen examination of the mastoid area was made by Dr. Dickinson, who reported:

The examination of the mastoid areas of your patient shows a large area of destruction which involves the entire left mastoid tip, extending well above the zygomatic ridge and well anterior to the auditory canal. A few cells can be seen in the periosteal region, but I think the destruction has extended to and involved the outer part of the petrous portion of the bone. When compared with the preoperative films the area of destruction is possibly slightly larger but not materially changed.

I have never seen anything resembling this pathology in the mastoid, and I am sure that had I seen this child originally that all I should have done would have been to describe the defect and suggest further investigation, including biopsy. See figure 4.

Roentgen therapy was advised. Between November 24 and December 15, 3,200 r was given with the use of high voltage and heavy filtration. On December 20 the wound was completely healed, and the ear was dry. On December 3 Dr. Dickinson made a roentgen survey of the skull, chest, long bones and spine of the patient and reported "no evidence of pathology other than the involvement in the left temporal region." This examination was later repeated with the same results.

Examination of the blood on December 19 showed erythrocytes 4,080,000, leukocytes 7,400, polymorphonuclears 66, lymphocytes 29, monocytes 4 and basophils 1; the hemoglobin estimation was 65 per cent, the color index determination was 0.8, and the nuclear index determination was 15. The determination of cholesterol in the blood was 208 mg. per hundred cubic centimeters. The high content of cholesterol in the blood would have suggested Christian's disease had not a diagnosis of Ewing's tumor been satisfactorily established postoperatively. Urinalysis gave negative results as did the Kolmer test on two occasions. The health of the patient is at present excellent, as evidenced by the accompanying photograph (fig. 5).

#### SUMMARY

Ewing's tumor is relatively rare and of particular interest to the medical profession for several reasons. Since both clinically and roentgenologically it closely resembles other pathologic conditions, the diagnosis is difficult; the cause is obscure; the mortality rate is excessively high; and methods of treatment are deplorably ineffective. The disease is described in its various aspects. Its occurrence is exceptionally rare in children under 4 years of age, and it very rarely elects the temporal bone as a site. The prognosis is always grave. A case of primary Ewing's tumor of the temporal bone in a child aged 2 years is reported.

#### ADDENDUM

In August 1942 roentgen examination was again made by Dr. Dickinson. Ten months after the operation osteal regeneration was clearly demonstrated in the roentgenogram, as shown in figure 6. On Dec. 11, 1943, the mother reported that the boy was in perfect health.



*Fig. 5. Photograph of the boy taken five months post-operatively.*

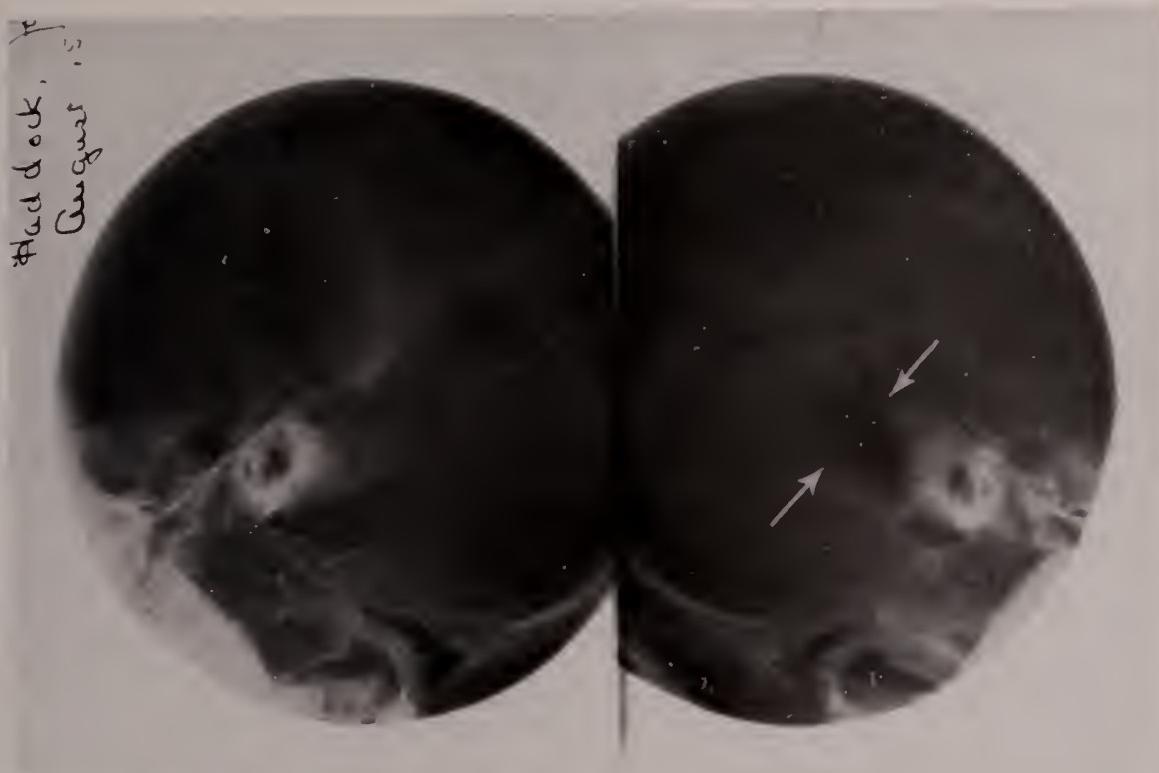


Fig. 6. Roentgenogram made ten months postoperatively showing the regenerative process.

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## A BRUTE

## PSEUDO GENUS HOMO

WM. WATSON MCKIBBEN, M. D.  
MIAMI

## FOREWORD

This is a story of courtesy and brutality.

George Washington, in a letter to his nephew, Bushrod Washington, in 1783, wrote, "Be courteous to all, but intimate with few, and let these few be well tried before you give them your confidence."

And, said Lamartine, "Brutality to a child or to an animal is cruelty to mankind—it is only the difference in the victim."

It is October, 1943, and Uncle Sam is at war with Germany and Japan. One hundred and eighty of the youngest, healthiest and most efficient Dade County physicians and surgeons have received their commissions and are in training or have left for foreign service. A year ago last spring their minds were in doubt, and they were sorely troubled readjusting themselves to an entirely new life. Now they have left behind them the problems of farewells and finance and find themselves philosophically facing the new problem of getting the war over as quickly and efficiently as possible. The many already overseas are taking the best possible care of the combatants, who are willing to risk their all for those at home.

Only 209 active physicians are left here in Dade County; they are over forty-five, partially incapacitated physically, or essential specialists, needed to take good care of the civilian populace and institutions. Of 16 Dade County pediatricians, 7 have gone into military service; 6 have become physically incapacitated; 3 are left to do the work of the original 16. These 3 work sixteen hours a day and conduct a telephonic information bureau for mothers at night. Not all mothers call up for appointments; many come without them. The result is the very thing that all child specialists try hard to avoid—a crowded waiting room with contact of babies and children and resulting possible spread of infection. To avoid this situation, less time is spent on each patient; thus, the examinations at busiest times tend to be superficial.

## THE CASE

The frail little new patient on the examining table appeared to be really sick; hyperpyrexia,

tachycardia, prostration and angina were noted on examination. Ordinarily, a specimen for culture would have been taken from the sore throat, but as there was no membrane on the tonsils and as there had been much summer "flu" or so-called "intestinal flu" since July, a smear was not made, nor a specimen for culture taken, in spite of the fact that the little 4 year old girl had had neither alum toxoid nor a Schick test.

An error of omission can sometimes trouble a physician as much as an error of commission. That night was a wretched one. As I lay tossing and turning, it seemed that morning dawned ever so tardily. Like a huge snowball being rolled slowly downhill, a hunch began definitely to gather substance, a hunch that there was a good chance of this little patient quickly becoming acutely ill with diphtheria; it took root and would not be squelched. Something had to be done about it and at once. After a hurried breakfast I made a quick jaunt to the city and to Southwest Sixth Street.

One of the things that distresses a physician most is that the parents may feel that he is trying to run up a bill, wearing out his welcome, so to speak. To set their minds at rest on this score, the father and mother of this child were assured that this was not a professional but a social call, to reassure myself that all was going well with tiny Mary.

Their basement apartment was between two buildings; daylight did not flow in from the sides nor through the dining room and kitchen in the rear. A vine prevented the light from coming through a small window in front of the crib in the corner beside the door. Besides a cradle containing an 8 month old baby boy, there were two chairs in the room. One was occupied by a sweet little mother, who held her sick child in her arms. In the other chair, a rocker, slumped a sullen-looking young man with his leg thrown carelessly over one of the arms. When he was addressed with a "Good morning," he did not answer, but continued to sulk. Apparently he was not drunk, but just in an ugly mood.

The mother was asked to face Mary toward the front door so that a little light could shine on the chest and into the child's throat, the white light of day being better than yellow artificial light for observing exudates and rashes. The young father continued to slump in his rocker. Since there was no other chair in the room ex-

cept the one in which the mother sat, it became necessary for me to kneel on the floor to bring my eyes on a level with the patient's throat. The view was not satisfactory; so the mother was asked to sit on the edge of the child's crib with Mary in her arms. Again the light entered the room from the door at an angle. There was so little room for the three of us on the one crib that I became annoyed with the whole situation, particularly with the sulking hulk slumped in the rocker. He seemed impassive and immobile. I grew impatient.

In commanding him to get me a chair from the dining room, I said somewhat abruptly, "In all the forty-three years of my life as a doctor, I have never before been treated with such humiliating courtesy. It is the first and, I hope, the last such experience I shall ever encounter. Since we never have seen each other before, it is difficult to understand such lack of sympathy and solicitude in behalf of your sick child as you have just shown. I am sure that if you visited me in my home, I would have the common decency at least to offer you a chair. Here in the South, where we are known for our hospitality, your lack of it seems entirely out of place."

Instead of being ashamed, he jumped up, grabbed little sick Mary out of her mother's arms, threw her across his lap and spanked her while she moaned piteously. Then he rushed through the front door, carrying his offspring under his arm against his hip as if she were a bundle, and pitched her onto the seat of his automobile. Hurriedly he backed the car out of the yard and went rolling down the street at high speed.

The little mother's face became a blend of shame and alarm. "Do you think he is drugged, drunk, or just plain brute?" I inquired.

"No, he is not drunk, but he is like that—just brutal to me and the children. He has even beaten our baby boy there in his cradle."

"Why, in his own home, was he so discourteous to a strange physician?"

"He doesn't like doctors. He didn't even want me to take Mary to your office yesterday."

"But it was made plain enough to him that there was to be no charge for this follow-up visit, was it not?"

"He earns good money as a plumber's assistant. He just got back from a good job up the coast."

"Doesn't he ever have a doctor for himself?"

"Oh, yes, only two weeks ago he went to see one."

"Then, for the sake of your little daughter, on his return have him take her to his doctor at once, without fail. Both tonsils are covered with what appears to be a diphtheria membrane. It may be a matter of life and death!"

Upon reaching my office, I telephoned the Judge of the Juvenile Court, who is a personal friend and a fellow University alumnus, and related the incident. I knew full well that he, as a man of great sympathy and understanding, would get results quickly. Naturally, he was incensed at such brutal treatment of this frail and sick little girl. He answered that he would send an inspector out to her house at once. His report and comments follow at the end of this account, as do those of a skilled psychiatrist.

Experienced psychiatrists, children's service bureaus and judges of juvenile courts will see in this true story defective paternal precept and example and faulty early environment. What will be the end result of this unequal union of a brute and a good woman? Will Mary become a grisette of the streets, or will the gentle mother overcome the serious handicap she faces and win out in the end? Did the Giver of All give the breath of life to this 8 month old boy so that he may later desecrate the title of manhood and have all mankind point the finger of scorn toward those who were responsible for his having been born? Will he be a criminal from birth and grow up like a weed untutored and unattended? The common causes of chronic inebriety and orphanage do not apply in this case.

I recall two facts retained in mind since youth. At the federal jail in Fort Smith, Ark., investigation disclosed that the immediate and prime cause of the downfall of nine tenths of those who committed crime was alcohol, and over 30 per cent of the criminals indicted and sentenced by the federal court were orphans who had never known a mother's care, nor kneeled at her side. They had never received the wise counsel of a doting father, whose example would stand through life like a monument to right doing and whose precepts should serve as a bulwark of strength to guard against the temptations of chance evil companions and bad literature.

Keep the young man on the job, busy at work or at play, shouldering responsibilities, and avoid prematurely pardoning the chronic criminal or the insane repeaters in crime.

Dear Dr. McKibben:

I was interested to receive your letter and remember the case to which you refer very well.

I hardly know how to explain this man's conduct other than at the hearing which we held in our Court, he indicated a total lack of confidence and complete prejudice against all doctors due to some unfortunate experience he claims to have had some time with your profession. After going fully into the matter, we directed him to take the child to a doctor of his own choosing under our supervision, which he did, and fortunately no ill physical effects, so far as the child was concerned, appeared to have occurred. He was put on a specific court order as to his future misconduct along this line.

Generally we call a person of this kind, in our work, a "mental case," meaning that he has a peculiar attitude about some particular thing. I agree with you that the conduct of this father was brutal and without justification, and he allowed the welfare of his child to come last in his thinking, when it should have come first.

You may use as little or as much of this statement in your paper as you may desire.

With kind personal regards, I am

Yours very truly,

(Signed) W. H. Beckham,

Judge, Juvenile and Domestic Relations Court.

Dear Dr. McKibben:

The situation which you outlined is a very unusual study of an overdeveloped, sadistic, masochistic couple.

In psychiatry, we usually speak of the male of the species as being sadistic and having as characteristics some of the components that go with sadism, such as aggressiveness and superior muscular strength. Women, from a psychiatric standpoint, on the contrary are usually considered masochistic, with a recessive personality, willingness to sacrifice for others and the ability to endure.

An exclusively masculine set of personality characteristics would, of course, constitute a rather disagreeable person. Likewise, an individual with exclusively feminine characteristics would be rather boring. Psychiatrically, most men and women are a mixture of sadistic and masochistic elements. The sadistic element usually predominates in men and the masochistic in women. In the case in question, the man was evidently a sadist, and his wife must have been the extreme opposite, else she would not have allowed the type of behavior to which her husband was accustomed. In other words, from an emotional standpoint the wife apparently liked being abused, while the husband enjoyed making everyone uncomfortable. The reason he spanked the child, rather than strike the doctor, was simply because the child was defenseless and therefore an easy object for his sadistic cruelty.

As to the influence such a home environment might have on children, it would, of course, be deplorable. I feel, however, that those engaged in social work are inclined to place too much emphasis on social conditions as a cause for crime. There are two reasons why a person becomes antisocial. I would say that perhaps environmental factors are most important. I do not, however, believe that hereditary factors can be discounted. Neglected, ill cared for children almost necessarily have an inferior heredity, as well as an inferior environment. I feel that both these factors play a part in the production of antisocial members of society. We see too many examples of persons overcoming the most unwholesome environmental situations and becoming outstanding citizens and of others with excellent environment descending to the gutter, to place the burden on environment alone.

With kindest personal regards and best wishes, I am

Sincerely,

(Signed) James L. Anderson, M. D.

## ABSTRACTS OF MEDICAL ARTICLES

COMMENTS ON A FEW SOUTH AMERICAN DISEASES, HANSON, HENRY, JACKSONVILLE, MONTH. BULL. DUVAL COUNTY M. SOC., NOV. 1943.

Out of his wide experience in public health work in South America Dr. Hanson comments on a number of diseases which present serious problems on that continent, most of which lies within the tropics. The incidence of malaria is particularly high in all of the countries except Chile and the southern extremity of Argentina. Deaths caused by benign tertian malaria in one province of Colombia he attributed to the low economic level of the populace.

In Peru especially and also in Ecuador and Colombia he observed bartonellosis, also called Oroya fever and, in Spanish, verruga peruana. The Bartonellas causing this infectious disease are basilar forms found inside red blood cells and are transmitted by a species of Phlebotomus. Diagnosis is made by means of blood smears, and fatal cases usually terminate before the characteristic warts develop. Since this organism shuns daylight, in Colombia the simple expedient of whitewashing the houses in which cases

had occurred prevented recurrence among their occupants.

Transmitted by the Phlebotomus intermedius, which is found in tea groves, the cutaneous form of leishmaniasis is of frequent occurrence, especially in Paraguay, Brazil and Bolivia. After the initial peculiar lesion heals, the leptomonadas, transmitted through the circulation, attack and destroy the cartilage of the nose, palate and larynx.

The author also observed various types of carate, but detected little or no impairment of health caused by the peculiar discoloration of the skin, which may be deep marine or slate blue, red, or light-colored as in ordinary vitiligo. The incidence of leprosy in its various forms is high throughout tropical America and probably highest in Brazil with 45,000 known cases. In British and Dutch Guinea particularly, the incidence of elephantiasis due to the Filarialoa is also high, and it occurs with greater frequency among women. Yellow fever and plague are great problems as is also typhus fever, which is prevalent throughout the high Andes.

CIRCULATORY DISTURBANCES IN PROSTATIC HYPERTROPHY, MALLORY, MEREDITH; MATHERS, FRED; ORR, LOUIS M.; AND KUNDERT, PALMER R., ORLANDO, ANN. INT. MED. 18: 835-840 (MAY) 1943.

An analysis of 29 cases of prostatic hypertrophy treated by surgical intervention in which there was a history of active myocardial failure or recent myocardial infarction is presented. The average age of the patients was 71 years. The average period of hospitalization was 21.9 days, the preoperative period averaging 11.5 days. The series illustrates the present trend of treating the old age group, formerly rejected as too great surgical risks because of advanced senility or serious cardiac defects by means of resection with excellent postoperative results and also great improvement of the failing cardiac muscle.

The authors concluded that patients with evidence of active circulatory failure are, in general, fair surgical risks in cases of prostatic hypertrophy. They observed that the removal of the obstruction to the urinary outflow aids greatly in effecting improvement of the cardiac condition and that failure to resort to surgical measures only aggravates this condition. Proper preoperative and postoperative treatment results, in their opinion, in a reduction of the mortality rate to a level comparable with that of the most favored surgical risks.



VITAMIN B IN HEARTBURN OF PREGNANCY, HART, B. F., WINTER PARK, AM. J. OBST. & GYNEC. 45: 120-122 (JAN.) 1943.

The results of vitamin B therapy in the treatment of 16 pregnant patients complaining of annoying heartburn are summarized. All but 3 were in the second half of the period of gestation and all experienced the heartburn for a period varying from two days to two months and averaging two weeks. The usual treatment with alkalies proved notably ineffectual when tried.

The majority of the patients responded to the administration of vitamin B in rather large doses. The most important component was the thiamin chloride, usually given in an initial dose of 50 mg. intravenously followed by 25 mg. a day orally.

Two patients, seven months pregnant, who attributed their symptoms to having previously had clinical pellagra, were completely relieved upon receiving daily large doses of the vitamin B

complex in the form of a yeast extract together with 200 mg. of nicotinic acid.

Of 2 hospitalized patients, one, in the fifth month of pregnancy, complained of severe heartburn on the second day of sulfathiazole medication for pyelitis. Complete relief in seventy-two hours followed the administration of thiamin chloride, initially 50 mg. intravenously and then 25 mg. twice a day orally. The other patient, in the sixth month of pregnancy, complained of severe nausea, vomiting, and heartburn of six days' duration. All of these symptoms disappeared within twenty-four hours after she received 50 mg. of thiamin chloride intravenously twice daily. With both of these patients gastric analysis demonstrated that the titer of hydrochloric acid in the stomach remained low until they were given nicotinic acid. This phenomenon suggests the possibility that the low gastric acidity was due to nicotinic acid deficiency.

In an addendum reference is made to further success with this therapy in the treatment of 10 additional patients. In two instances benefit resulted only after an ampule of suprarenal cortex was given subcutaneously conjointly with a fourth intravenous injection of thiamin chloride, this result apparently bearing out experimental evidence that suprarenal cortex increases the activity of thiamin chloride.



PREFRONTAL LOBOTOMY IN CHRONIC SCHIZOPHRENIA, BENNETT, A. E., KEEGAN, J. J., AND WILBUR, C. B., OMAHA, J. A. M. A. 123: 809-813 (NOV. 27) 1943.

In the light of present knowledge, lobotomy should be continued in certain selected chronic cases of schizophrenia in order to restore many disabled persons to social usefulness, in the opinion of these authors, who report 5 cases of aggressive paranoid schizophrenia. This operation effected a good social recovery in 4 cases; in 1 case of the catatonic type, the patient failed to improve.

The problem of social rehabilitation of these patients opens up a new field of social and psychiatric nursing technics and needs more study to aid lobotomized patients to resume normal living.

The operation of prefrontal lobotomy for certain mental disorders was introduced by a Portuguese neurosurgeon, Egas Moniz, in 1936 and in this country in the same year by Walter Free-

man, M. D., and J. W. Watts, M. D. As the authors point out, the operation has been established as a useful procedure in psychiatric treatment. They believe its usefulness should continue to be studied, and that it should be limited to chronically disabled psychotic patients who have been unimproved by other therapies. It should not be used in psychoneuroses and affective states until the patients have proved totally refractory to other methods.



THE PSYCHOSOMATIC MANIFESTATIONS OF FILARIASIS, ROME, HOWARD P., LIEUT. (MC) USNR., AND FOGLER, R. HARWOOD, LIEUT. COMDR. (MC) USNR., J.A.M.A. 123:944-946 (DEC. 11) 1943.

The specific conditions discussed by the authors in this paper are the psychosomatic symptoms that may be associated with filariasis, an infection with any of the various species of filaria, a parasite widely distributed but particularly common in tropical countries. The parasite may produce an infection of the lymph glands, causing their enlargement and inflammatory swelling of the parts affected. The scrotum frequently is involved.

In opening their discussion, the two physicians say that "prosecution of the war in tropical climates has not only stimulated interest in parasitology and tropical medicine but also, coincidentally, ramified the field of psychosomatic medicine. Diseases which only a few years ago were labeled 'rare and exotic' are beginning to rival the more familiar illnesses for preferential medical consideration."

Many observers, they point out, have noticed the mood disturbance associated with the acute phases of tropical parasitic infestation, which is particularly true of filariasis. As with all systemic infections, fatigue, irritability, mild depression and anxiety are present, and, in addition, there is a pervading element of apprehension and concern in the case of white troops which is absent in the infested native population. The cause of this apprehension is obvious on inquiry into the setting and circumstances in which this disease has occurred in the members of the armed forces. The great majority of troops stationed in the South Pacific are young unmarried men, many of whom are away from their immediate home surroundings for the first time. It is natural that the cir-

cumstances, since they are conducive to pronounced feelings of insecurity, constitute a maximal text of adaptability. The life soldiers lead in the tropical jungles of the Pacific islands predisposes them to the disruption of the feeling of affiliation which is essential for their personal and social security. The omnipresent threat of attack is an added disturbance, and the contrast between the primitive setting and terrifying techniques of warfare is all the more disturbing. This is the background on which is elaborated the psychologic factors of the various tropical diseases to which they are susceptible.

It has been widely appreciated, the authors state, that with operations being conducted in African, Asiatic and Pacific theatres, the problems incident to cultural and environmental contacts would play an important role. Fuller information concerning the peoples, customs and indigenous diseases of these areas would dispel many strange beliefs concerning them. Bugaboos and superstitions still distort the thinking of many, exaggerating their fears and perverting their judgments. Particularly is this true of the beliefs concerning tropical disease and the responsibility of the native population for their dissemination. Not only is the public perplexed, but also, much too frequently, the medical profession is uninformed about their cause, nature, complications and sequelae. The psychologic overemphasis which is given to the sequelae of tropical disease can be minimized by the intensive education of all troops on duty in endemic areas. Fortified by authentic information, infested persons will be better able to cope with the problems which arise from the need to explain their disease.

The authors explain that mosquitoes serve as the intermediate host of filariasis and two species are predominantly responsible for its transmission. Fear of deformity, impotence, sterility and ostracism are common reactions among soldiers and sailors and must be combated. The medical officer is the ideal person to render this valuable service. He is known to the men, he has had the opportunity to demonstrate his technical competence, and he is serving with them, sharing their hardships and experiences. Simple, non-technical explanations of the pathology of the disease, supplemented by illustrative charts and blackboard diagrams are recommended to allay these fears.

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JOHN S. MC EWAN, M.D., 1925.....Orlando  
II. MASON SMITH, M.D., 1926.....Tampa  
JOHN A. SIMMONS, M.D., 1927.....Arcadia  
FREDERICK J. WAAS, M.D., 1928.....Jacksonville  
HENRY C. DOZIER, M.D., 1929.....Ocala  
JULIUS C. DAVIS, M.D., 1930.....Quincy  
GERRY R. HOLDEN, M.D., 1932.....Jacksonville  
WILLIAM M. ROWLETT, M.D., 1933.....Tampa  
HOMER L. PEARSON, M.D., 1934.....Miami  
HERBERT L. BRYANS, M.D., 1935.....Pensacola  
ORION O. FEASTER, M.D., 1936.....St. Petersburg  
EDWARD JELKS, M.D., 1937.....Jacksonville  
W. HENRY SPIERS, M.D., 1938.....Orlando  
LEIGH F. ROBINSON, M.D., 1939.....Ft. Lauderdale  
J. SAM TURBERVILLE, M.D., 1940.....Century  
GILBERT S. OSINCUP, M.D., 1942.....Orlando

\*Alternate for member in Armed Services.

## The Journal of The Florida Medical Association

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## PHYSICIANS' TEMPORARY LICENSES

The problem of granting temporary licenses during the war emergency for relocating physicians in particular counties has been perplexing to all concerned. A plan, submitted by Hon. J. Tom Watson, Attorney General, was discussed and tentatively approved at a meeting held in Jacksonville on Thursday, January 6, at which were present representatives of the State Defense Council, the Board of Governors of the Florida Medical Association, the State Board of Medical Examiners, the State Board of Health, and the Procurement and Assignment Service. It is to be submitted to these organizations for ratification.

The plan, drafted under the statutory emergency powers of the State Defense Council to meet emergency needs during the war, provides that a directive be issued by the Governor to the State Defense Council, authorizing the placement of physicians in localities where they are needed. The existence of a shortage must be determined by the county medical society, which must then file a certificate of need for additional physicians when necessary. Approval of the plan must also be secured from the Board of Governors of the Florida Medical Association, the State Board of Medical Examiners, and the State Board of Health. In no event shall the license continue in effect longer than six months after the end of World War II.

If this plan is approved by the organizations designated, a complete report, explaining all details, will be published in next month's Journal

## AMERICAN COLLEGE OF SURGEONS TO HOLD 22 WAR SESSIONS

Twenty-two cities distributed throughout the United States and Canada have been selected by the American College of Surgeons as headquarters for one-day War Sessions to be held in March and April, 1944. Advancements in military medicine and developments in civilian medical research and practice under the spur of the war emergency will be presented by authorities representing governmental agencies and by civilian physicians and surgeons.

The meetings will be open to the profession at large, including medical officers of the Army and the Navy, residents, interns, medical students, and executive personnel in hospitals. For the latter special hospital conferences, to be held simultaneously with the scientific sessions, are being arranged.

On Monday, March 27, at Jacksonville in the George Washington Hotel, a meeting will be held for the district including Florida, Georgia, North Carolina and eastern Tennessee.



## HOSPITAL SERVICE PLAN

The Florida Hospital Association adopted the following resolution at a special meeting held in Orlando, November 22, 1943:

WHEREAS: the American Hospital Association has urged full coverage of Blue Cross Hospital Service Plans for all states and communities, and

WHEREAS: No coverage now exists in the State of Florida, be it

RESOLVED: That the Florida Hospital Association in a special meeting on November 22, 1943, adopt this resolution:

That a committee be appointed to perfect the organization of a Blue Cross Plan for Florida, to secure the consent of the State Insurance Commissioner to operate such a plan under the existing law pertaining to Duval County, to arrange for securing the necessary initial working capital, and the committee be empowered to:

- Secure the agreement of the necessary number of hospitals to become member hospitals, and properly cooperate with such a plan.

- Select and employ a full time director for the plan.

- Select a Board of Trustees, a minimum of 50% of whom must be hospital representatives, nominations to be secured from the initial hospital members.

- Formulate proposed by-laws, rules, and regulations, subscriber and hospital contracts for submission to the Board of Trustees for adoption.

- And, any other procedures necessary to activating the Florida Blue Cross Plan as soon as it is possible so to do.

The special Blue Cross Committee, comprised of H. A. Cross, chairman, superintendent, Good Samaritan Hospital, West Palm Beach; W. A. Nelles, superintendent, Riverside Hospital,

Jacksonville; and J. A. Bowman, superintendent, Munroe Memorial Hospital, Ocala, has begun its work of drafting necessary contracts and the determination of rates and benefits.



## VOLUNTARY CONTROL OF PATENT MEDICINE ADVERTISING

The time seems ripe for more positive voluntary control by American newspaper publishers of the more blatant advertisements of proprietary remedies in order to avoid the danger of control by governmental decree such as has taken place in Argentina. The Journal of the American Medical Association for December 4 suggests in commenting on a recent action taken by the publishers of London, England, newspapers aimed at bringing under control such advertising abuses. The Journal continues:

The better newspapers in this country for years have attempted to exclude the more blatant advertisements of proprietary remedies. A few—too few—have even banned advertising of this class altogether. In Britain, where the situation with regard to extravagant claims has been generally much worse than here, a long step forward has just been taken. As told elsewhere in this issue, London newspapers, through their trade association, voluntarily have adopted regulations which should greatly improve the standard of control over such advertising claims. In this country too the time seems ripe for more positive voluntary action by publishers to avoid the danger of control from above by decree, as in Argentina where almost complete government control of drugs and drug advertising has been established.

In the same issue of The Journal, its regular London, England correspondent reports that:

Blatant claims to cure all sorts of diseases made in the newspaper advertisements of proprietary medicines have long been a scandal. At last, this practice is to be checked. The Newspaper Proprietors Association has unanimously adopted the following rules: 1. No advertisement will be accepted for any medicine or treatment which is claimed to be effective in Bright's disease, cancer, tuberculosis, diabetes, epilepsy, fits, locomotor ataxia, disseminated sclerosis, osteoarthritis, spinal, cerebral and venereal diseases, lupus or paralysis or for preventing any of these ailments; for the cure of amenorrhea, hernia, blindness, rheumatoid arthritis or any ailment of the auditory system; for procuring miscarriage; for the treatment of habits associated with sexual indulgence, or for any ailment connected with these habits. 2. No advertisement will be accepted from any advertiser who by printed matter, orally or in his advertisement, undertakes to diagnose any condition or to receive a statement of any person's symptoms with a view to advising or providing for treatment by correspondence. 3. No advertisement will be accepted containing a testimonial other than one limited to the actual views of the writer, or any testimonial given by a doctor other than a recognized British medical practitioner. 4. No advertisement will be accepted containing illustrations which are distorted or exaggerated to convey false impressions. 5. No advertisement will be accepted which may lead persons to believe that the medicine emanates from any hospital or official source, or is any other than a proprietary medicine advertised by the manufacturer for the purpose specified, unless the advertising

agent submitting the copy declare that the authority of such hospital or official source has been duly obtained.

These rules are now in operation in all of the London morning, evening and Sunday newspapers. Also all advertisements will be submitted to medical scrutiny and the products advertised to chemical analysis if this is considered necessary. This is the first time leading newspapers have unanimously laid down and insisted on a standard of control over the claims made in advertisements.



## NEUROPSYCHIATRY'S IMPORTANCE IN ARMED FORCES

A soldier suffering from what would ordinarily be called a nervous breakdown, a condition classified as a neuropsychiatric disorder, was punished quite unnecessarily by a general. This incident serves to focus attention again on the exceeding importance of proper organization of neuropsychiatry in the medical services so that the most possible can be done to prevent situations of this type in the future. The Journal of the American Medical Association for December 4 points out. It adds:

With the beginning of the Selective Service examinations the importance of preliminary neuropsychiatric study became clear. Just recently the Selective Service Administration has improved its technic for this purpose. Originally it was contemplated that great numbers of neurophysicians would be associated with the examinations of men for military service especially on the induction boards and that sufficient time would be allowed for such study. The speed of recruitment and the lack of sufficient personnel, as well as the failure to develop dependable technics, combined to prevent the type of study that needs to be made if any considerable number of potential cases is to be eliminated from admission to the service. Up to April 1943 almost half a million men had been rejected for psychiatric reasons. About one third of all casualties now being returned from overseas are neuropsychiatric. The strain of this war effects leaders, with the added stress of leadership, even more than it does the men in subordinate rank. Already it is clear that constant attendance by qualified neuropsychiatrists may serve to detect potential breakdown among aviators and to restore men in such condition to active service far more quickly than would otherwise be the case. The death of Col. Roy Halloran deprives the division of neuropsychiatry of the Medical Department of the Army of a distinguished leader who was well on the way to the development of adequate personnel and improved services. A successor has not yet been appointed. Since neuropsychiatric breakdown now constitutes a leading cause of disability, resulting in the loss of services of tremendous numbers of men both in the Army and in the Navy, the Secretaries of War and of Navy might well consider whether neuropsychiatry should be a major division in the organization of the administration of the Medical Departments of the Army, the Navy and the Air Forces.

## NEED FOR RETENTION OF INDIVIDUALISM IN MEDICINE

A plea for the retention of individualism in the field of medicine was voiced on December 18 by John Temple Graves, II, Alabama author and newspaper columnist in an address to the graduates of the Medical College of Virginia. Graves urged that the doctor "never become an employee of the State" or "an order-taking agent of a government bureau." He said:

If this war and this home reaction are indeed victories of the individual, the individual is going to be put to it as never before to be a whole individual.

None of us can afford, and our country can't afford, to have specialization rob us of whole men. We can't afford to have lawyers who don't know economics and how the world is moving in an economic sense; we can't afford to have economists without a proper knowledge of the length and import of law.

At a time when the world is so crowded and close that not one of us can move without having somebody else move over, when everybody's dream and everybody's work are related to everybody else's the need is for whole men who know not only their own work, but what is around it.—(AP).

### MEDICAL AND SURGICAL SUPPLIES NEEDED

*Editor's Note—The following letter is published at the request of Dr. Joseph Peter Hoguet, Medical Director of the Medical and Surgical Relief Committee of America, as it may be of interest to our readers:*

January 1st, 1944.

Dear Doctor:

There is a critical need for medical and surgical supplies that may lie hidden and forgotten in your office: discarded or tarnished instruments, surplus drugs, vitamins, infant foods. Collected, packaged, sent to the Medical and Surgical Relief Committee, they can play a vital role in its program of medical relief for the armed and civilian forces of the United Nations.

Surgical instruments and medicines are sought-after by physicians and pharmacist's mates of our Navy, are hungrily snatched by the medical corps of our Allies. The work of war-zone hospitals and welfare agencies is too often crippled by the lack of medical supplies. Community nurseries in this country, refugee camps abroad cry out for vitamins and baby foods for their ill-nourished charges.

In the pages of this journal you may have read about the Committee. It has supplied over 900 sub-hunting and patrolling ships of the Navy with emergency medical kits; equipped battle-dressing stations on battleships, destroyers and cruisers. The Committee's roll-call of medical requests—not one of which has been turned away—reads like a world geography: the Fighting French in North Africa and Tahiti; the Royal Norwegians in Canada and Iceland; the West Indies; South and Central Africa; China; India; Great Britain; Yugoslavia; Greece; Syria; Russia; Alaska and of course, the United States.

To meet the demands that pour into headquarters, the Committee needs all types of instruments, especially clamps, scalpels, forceps and all kinds of drugs from iodine to sulfa products. By contributing what you can spare, you will help speed another shipment of sorely-needed medical aid.

Very sincerely yours,

(Signed) Joseph Peter Hoguet, M. D.

Medical Director

420 Lexington Avenue, New York, N. Y.

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

Dr. and Mrs. Clarence Bernstein of Bartow announce the birth of a daughter, Jill, on September 23.

Dr. and Mrs. P. H. Guinand of Clearwater announce the birth of a son, Joel Henry, on December 5.

### MARRIAGES

Dr. Harold O. Hallstrand of Tallahassee and Miss Marjorie Rennacker of Willmette, Ill., were married on October 20.

### DEATHS

Dr. Raymond B. Ramage of Jacksonville died on December 22.

Dr. Cecil H. Wilson of Bartow died on December 18.

Dr. Frank T. Barker of Tampa died on January 5.

Dr. William J. Holton of Plant City died on January 7.

## STATE NEWS ITEMS

Dr. H. Marshall Taylor of Jacksonville, as president of the American Laryngological, Rhinological and Otological Society, visited the various Section meetings of this organization held during the month of January. The meeting of the Western Section was held in Los Angeles, the Eastern Section in New York City, the Middle Section in Cleveland, and the Southern Section in Atlanta.

Dr. Taylor, for many years prominent in his profession, has also served as president of the Florida Medical Association, the American Bronchoscopic Society and the Southern Medical Association, and as chairman of the Section on Laryngology, Otology and Rhinology of the American Medical Association.

The following initiates from Florida were accepted into fellowship in the American College of Surgeons in 1943: Drs. Donald M. Baldwin and Ashbel C. Williams of Jacksonville, and Drs. Norman W. McLeod, Donald W. Smith and Richard F. Stover of Miami.

Dr. T. H. Bates of Lake City was the guest speaker at a local nurses' aid class in December. His subject was "The Care of the Baby."

Dr. Horace A. Day of Orlando was the guest speaker at the local Civitan Club's meeting on November 24.

Dr. Waldo Horton of Winter Haven was the guest speaker at the weekly meeting of the local Rotary Club on December 14.

Dr. E. Bryant Woods of Tampa was the guest speaker at the St. Petersburg Woman's Club on December 10. His subject was "Synthetics."



Dr. B. F. Hodsdon of Miami was honored at a surprise reception on his seventy-eighth birthday in December. Dr. Hodsdon came to Florida in 1911 and retired two years ago.

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#### JOEL WALTER HOOD

Dr. J. Walter Hood of Ocala died on November 22 at the age of 92. He had been in declining health for more than a decade, following a stroke of paralysis which compelled him to remain in bed most of the time.

Dr. Hood, the son of Rayburn Gaines Hood and Safronia David Hood, was born on his father's plantation in Harris County, Ga., on September 10, 1851, the oldest of six children. He was 15 years old when the war between the states was declared, and he served by assisting his father, who was a large cotton grower.

After completing high school at Whitesville, Harris Co., Ga., he enrolled at the University of Louisville, from which he was graduated in 1884. In 1890 he came to Ocala where he was to continue the practice of medicine until his retirement some years ago, and was to reside until his death. On July 26, 1906 he was married to Caroline Barco Long, who survives him.

During World War I Dr. Hood served for a short time in the medical corps. Although confined to his home during the present war, he was able to assist many people in establishing their birth records.

He was a Master Mason and a devout member of the First Baptist Church. He was an honorary member of the Marion County Medical Society and of the Florida Medical Association, and a member of the American Medical Association.

Possessed of a cheerful and kind disposition, Dr. Hood was quick to extend a helping hand to the sick and discouraged. A wave of sadness swept over the city when the news spread that "Dr. Walter," as he was familiarly known to his patients and friends, had passed away.

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#### RAYMOND BROCK RAMAGE

Dr. Raymond B. Ramage died at his home in Jacksonville on December 22, 1943, at the age of 53.

Dr. Ramage was born in Alabama, the son of James B. and Dorothy Robinson Ramage. He received his preliminary education in the public schools of Lafayette, Ala., and his medical training at Vanderbilt University School of Medicine, from which he was graduated in 1914. Later he did postgraduate work at Cincinnati General Hospital, New Haven Hospital and at Tulane. He served for a time on the staff of the Johns Hopkins Hospital in Baltimore.

In 1925 Dr. Ramage came to Jacksonville where he built up an extensive practice in his specialty of internal medicine. He was a member of the Duval County Medical Society, the Florida Medical Association, and the American Medical Association. He was also a member of the Avondale Baptist Church, the Riverside Lodge F. & A. M., and the Knights of Pythias.

Survivors are his widow, Mrs. Martha Cornele Ramage, and one son, Raymond C. Ramage, who was graduated from Duke University last December. Funeral services were held in Jacksonville and interment services and burial at Opelika, Ala.

Dr. Ramage, who was very popular with his colleagues, leaves a host of friends in Jacksonville who mourn his untimely passing.

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#### CECIL HENRY WILSON

Dr. Cecil H. Wilson of Bartow died at his home on December 18, 1943, after an illness of several months. He was 55 years old. He was the son of Dr. F. M. and Mrs. Adelide C. Wilson, both members of pioneer families of Polk County.

Dr. Wilson was graduated from the Atlanta College of Physicians and Surgeons in 1913, and soon thereafter came to Bartow to establish his practice. He numbered among his patients many underprivileged citizens, to whom he showed special consideration and thoughtfulness, not only in prescribing for them but in providing the medicines they needed. He was greatly

interested in the welfare of the colored people of the community and was a real friend to them, many times acting as advisor and counselor for them in their personal affairs. At his request the colored people participated in the funeral service, half of the church being reserved for them. Music for the occasion was furnished by a white quartet and by a colored quartet; the pastors of the colored Baptist and Methodist churches, who attended the services, offered prayers for the family and paid tribute to the deceased.

He is survived by two sons, Ashton Wilson of Ray, Colo., and Thomas Wilson of Washington; a brother, Leighton Wilson of Tampa; and two sisters, Mrs. Eugenia Davis of Benton, Ark., and Mrs. W. O. Bass of Houston, Tex.

### COMPONENT COUNTY SOCIETIES

#### DADE

The annual meeting of the Dade County Medical Society was held on Tuesday, December 7, at the Jackson Memorial Hospital. Dr. Homer L. Pearson presided.

Reports were presented by the officers and committee chairmen, after which the following officers were elected to serve for the year 1944: president, Dr. Wiley M. Sams; vice president, Dr. Scheffel Wright; secretary, Dr. J. J. Nugent, and treasurer, Dr. Colquitt Pearson.



#### DUVAL

Maj. Milford B. Hatcher, Army Medical Corps officer stationed at Finney General Hospital, Thomasville, Ga., was guest speaker at a meeting of the Duval County Medical Society held on the evening of January 4 at St. Luke's Hospital, Jacksonville. His subject was "Penicillin." He was introduced by Dr. Francis Copp, vice president of the society and program chairman. Dr. J. G. Lyerly, president, presided at the meeting. Interest in the subject was reflected in the great variety of questions put by members during a question and answer period.

Dr. J. G. Lyerly was elected president of the Duval County Medical Society at a meeting held at St. Luke's Hospital, Jacksonville, on Decem-

ber 7. Dr. J. M. Bryant was named president-elect. Other officers elected were Dr. F. A. Copp, vice president; Dr. O. E. Harrell, secretary, and Dr. J. A. Beals, treasurer.

#### ESCAMBIA

The Escambia County Medical Society held its December meeting at the Pensacola Hospital on the evening of the 14th. A motion picture on "Diagnosis and Treatment of Venereal Disease" was shown and discussed by Dr. Morris Leider, USN, who is in charge of venereal disease control work at the Pensacola Naval Air Training Center. Dr. Ford Williams, venereal disease control officer of the U.S.P.H.S., also spoke on this subject.

The election of officers for 1944, which was held following the scientific program, resulted in the selection of Dr. John K. Turberville of Century as president; Dr. Herbert L. Bryans, vice president, and Dr. Lee Sharp, secretary and treasurer.

#### HILLSBOROUGH

Dr. Ralph S. Torbett was elected president of the Hillsborough County Medical Society at the annual meeting of that organization, which was held in December. Other officers elected were Dr. Lee T. Rector, vice president, and Dr. Charles M. Gray, secretary and treasurer.

#### LEE

To the Lee County Medical Society goes the distinction of being the first component society to remit 100 per cent of its membership dues for 1944. This society placed itself first on the honor roll last December when 1944 dues for its entire membership were received by the State Association treasurer. Congratulations! Officers for the current year are: president, Dr. M. F. Johnson; vice president, Dr. C. G. Merrick, and secretary-treasurer, Dr. W. A. Harrison.

At a meeting held in December, the members of this society agreed to share the job of giving preliminary physical examinations to draftees. The action was taken following the resignation of Dr. Baker Whisnant, who has served for three years as examiner for the local draft board. It was decided to cooperate with the board in every way possible, but that rather than load the burden on any one physician, each doctor will notify the board of the number of men he can examine.



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## MARION

The annual meeting of the Marion County Medical Society was held at the Hotel Harrington, Ocala, on December 16. The following officers were elected to serve for 1944: president, Dr. Robbins Nettles; vice-president, Dr. H. Durham Young, Jr.; secretary-treasurer, Dr. B. F. Drake. Dr. T. Hartley Davis was chosen delegate to the annual State Association meeting, with Dr. Robert D. Ferguson as alternate.

## ORANGE

The annual meeting of the Orange County Medical Society was held Wednesday evening, December 15, 1943. Officers, delegates and alternates elected for 1944 are as follows: president, Dr. Duncan T. McEwan; president-elect, Dr. Louis M. Orr; vice president, Dr. Roland T. White; secretary, Dr. A. C. Kirk; treasurer, Dr. Walter A. Weed; trustee, Dr. Meredith Mallory; delegates to State Medical Association, Dr. Spencer Folsom (two years), Dr. T. E. McBride (two years), Dr. H. A. Day (one year), Dr. J. S. McEwan (one year); alternates, Dr. J. A. Pines (two years), Dr. D. T. McEwan (two years), Dr. W. E. Sinclair (one year), Dr. Hewitt Johnston (one year).

The following is an abstract from the annual report of Dr. J. A. Pines, secretary:

The Orange County Medical Society was organized on May 26, 1908, with nine charter members. Dr. J. S. McEwan is the only surviving member of this original group. During the intervening years up to the present time 195 physicians have joined our society.

At the beginning of 1943 our roster shows an active membership of 63, with 32 members in the armed forces of our country, making the present total membership 95.

During the year 1943 we added five new members to our society. And during this time we have lost two of our members by death, Dr. J. F. Gardner of Winter Park and Dr. T. M. Rivers of Kissimmee.

We held our annual banquet on January 20 at the University Club. Eleven regular meetings were held, at which scientific programs were given.

We have all worked hard during the past year, due to the shortage of physicians as one-third of our membership is in the Army or Navy. Nevertheless we have kept up with the advance in medical science and our attendance at regular meetings has averaged 33. All members have shown a willingness and a spirit of cooperation to help make and keep our society the best in the State.

## PALM BEACH

Dr. James L. Carlisle was elected president of the Palm Beach County Medical Society at a meeting held on December 13 at the Good Samaritan Hospital, West Palm Beach. Other officers elected were Dr. D. W. Martin, vice presi-

dent; Dr. E. W. Stephens, secretary, and Dr. W. C. Williams, Jr., re-elected treasurer.

Also present at this meeting were Maj. James M. Harsha, Camp Murray post-surgeon, and members of his staff, who extended an invitation to the Society and to the staff of the Good Samaritan Hospital for a joint dinner meeting the first part of January at Camp Murphy.

## PASCO-HERNANDO-CITRUS

Early in January the Pasco-Hernando-Citrus County Medical Society forwarded to the State Association treasurer 100 per cent of its membership dues for the current year, thereby becoming the second society to pay its entire dues assessment for 1944. Congratulations!

The regular meeting of this society was held at the home of Dr. and Mrs. W. H. Walters of Lacoochee, Thursday evening, December 9. The following officers were elected for 1944: president, Dr. S. C. Harvard; first vice president, Dr. P. J. Hudson; second vice president, Dr. J. T. Bradshaw; secretary and treasurer, Dr. G. R. Creekmore.

Dr. James L. Estes of Tampa, the guest speaker, reported an interesting case of pyelonephrosis, which he illustrated with roentgenograms.

The members of the society were urged to make contributions to the National Physicians' Committee, and an amount of \$2.00 per member was suggested.

Guests present were Dr. James L. Estes of Tampa and Dr. H. D. Young of Wildwood. Members present were Drs. J. T. Bradshaw, C. L. Carter, G. R. Creekmore, S. C. Harvard, P. J. Hudson, W. W. Jones and W. H. Walters.

Dr. S. C. Harvard invited the society to meet with him in Brooksville on January 13. A report was submitted by Dr. G. R. Creekmore, secretary and treasurer of the Society.

A vote of thanks was extended to Dr. and Mrs. Walters who entertained the members and guests at a quail dinner.

## PINELLAS

The members of the Pinellas County Medical Society held a dinner meeting at the Detroit Hotel, St. Petersburg, on December 3. Dr. A. S. Anderson presented a paper on "Penicillin," and Dr. Roscoe D. Cummins, a member of the local dental society, spoke on "Closer Cooperation Between Dentistry and Medicine."



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TOMORROW'S MEDICINES FROM TODAY'S RESEARCH

## SEMINOLE

The regular meeting of this society was held on board the yacht, Skylark, on Tuesday evening, December 14; the host was Mr. Gene Roumillat, owner of the yacht.

The following officers were elected for 1944: president, Dr. Samuel Puleston; vice president, Dr. J. A. Smith; secretary-treasurer, Dr. Leland H. Dame; censor for three years, Dr. George H. Putnam.

Action was taken to send a telegram expressing good wishes to Dr. H. D. Smith who is ill in a Philadelphia hospital.

A sumptuous dinner consisting of venison, wild turkey and refreshments was served aboard the yacht. Present were: members—Drs. L. H. Dame, Wade H. Garner, W. T. Langley, Samuel Puleston, George H. Putnam, G. S. Selman, J. A. Smith and J. N. Tolar; guests—Lieut. Commander S. S. Sidenberg, Lieut. D. A. Stewart and Mr. J. L. Ingle.

## VOLUSIA

Dr. T. H. Dillard of DeLand was elected president of the Volusia County Medical Society at a meeting held at the Geneva Hotel in Daytona Beach on December 14. Other officers chosen were: Dr. George M. Green, vice president; Dr. Robert L. Miller, secretary-treasurer (re-elected). It was decided to hold the next meeting at New Smyrna Beach on January 11. Guests at this meeting were Dr. Miroz, Lieut. Comdr. Hargrove and Lieut. Comdr. L. J. Newell.

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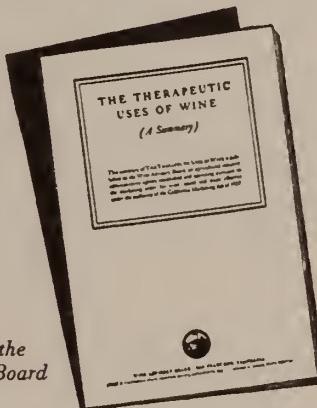
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## FACTS DOCTORS SHOULD HAVE ON

# WINE IN THE DIET



Published by the  
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DISCUSSIONS of wine's historical uses . . . the caloric content of wine . . . its dextrose and levulose content . . . its vitamin and mineral constituents . . . the assimilability of the ferrous iron in wine . . . etc. . . . form one of the chapters of *The Therapeutic Uses of Wine (a Summary)*. This review in monograph form has been prepared by competent medical authorities. It should be of interest to specialists in many fields as well as to the general practitioner.

**THE CONTENTS INCLUDE:** Sections on the actions of wine on the gastro-intestinal system, the cardio-vascular system, the kidneys and urinary passages, the nervous system and the muscles, and the respiratory system. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and the convalescent. The value of wine as a vehicle for medication. The contraindications to the use of wine. And an extensive bibliography for those who may wish to pursue the subject further.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

A copy of *The Therapeutic Uses of Wine* is available on request to any member of the medical profession. Write for it, to the Wine Advisory Board, 85 Second Street, San Francisco 5, California.



## ADVERTISERS' NOTES

### SEVEN WAYS OF MEETING DAILY MILK NEEDS

**FLUID MILK.** To insure adequate amounts of milk in the diet, nutritionists recommend that part of the daily milk needs be used in the fluid form as a beverage. Fluid milk may also be used with cereals, in soups, chowders, scalloped or creamed dishes and deserts.

**ICE CREAM.** Ice cream contains all of the food value of milk, although in different proportions. One third quart (1 1-3 cups) of vanilla ice cream is equivalent in calcium, phosphorus and protein content to one cup of fluid whole milk. Ice cream, too, is a perfect choice for those who are over-weight because it is a low calorie dessert while high in health values.

**CHEESE.** One and one-fourth ounces of American (Cheddar) cheese are equivalent in calcium phosphorus and protein content to one cup of fluid whole milk. Cheese may be used in soups, main dishes, sandwiches, salads and desserts.

**BUTTERMILK AND FLUID SKIM MILK.** Equal volumes of buttermilk, fluid skim milk and fluid whole milk contain equivalent amounts of calcium, phosphorus and protein. However, as practically all of the butterfat has been removed from skim milk and many of the buttermilks, these two products are low in calories and vitamin A value.

**DRY WHOLE MILK.** Four tablespoons of dry whole milk combined with 7-8 cup of water are equivalent in food value to one cup of fluid whole milk. Dry whole milk, when reconstituted with water, may be used for all purposes for which fluid whole milk is used.

**EVAPORATED AND CONDENSED MILKS.** One-half cup of evaporated milk, diluted with an equal volume of water, is equivalent in food value to one cup of fluid whole milk. It may be used for general cooking purposes, cocoa and hot chocolate, and with coffee or tea. One-half cup of condensed milk, diluted with an equal volume of water, is equivalent in food value to one cup of fluid whole milk except for the caloric content. The caloric content of the diluted condensed milk is about double that of an equal volume of fluid whole milk because of the sugar added during processing.

**DRY SKIM MILK.** Three and one-half tablespoons of dry skim milk combined with 15 tablespoons of water are equal in calcium, phosphorus, and protein content to 1 cup of fluid milk. If supplemented with 2½ teaspoons of butter, it is equivalent to the total food value of 1 cup of fluid whole milk.

### DIABETIC IDENTIFICATION TAGS

At the suggestion of the Medical Division of the U. S. Office of Civilian Defense, to prevent dangerous delay in diagnosis and to insure proper treatment during unconsciousness or coma, Eli Lilly and Company, Indianapolis 6, Indiana, in cooperation with the American Diabetes Association, will provide metallic identification tags to be worn by diabetic patients or carried in the pocket. The inscription reads "DIABETIC, If Ill Call PHYSICIAN." No advertising of any sort appears on the tags, which will be supplied to the medical profession on request.

### EXECUTIVE CHANGES IN UPJOHN CO.

Following a special meeting of the Board of Directors of The Upjohn Company, Kalamazoo, Mich., on December 14, President Donald S. Gilmore announced two important executive changes.

Mr. C. V. Patterson, Vice President and Director of Sales, was made Vice President and Director of Production. Mr. E. H. Schellack was elected to the Board of Directors and was made Vice President and Director of Sales.

The untimely death of Dr. Harold S. Adams, recently elected Vice President and Director of Production, precipitated this action. During the past several



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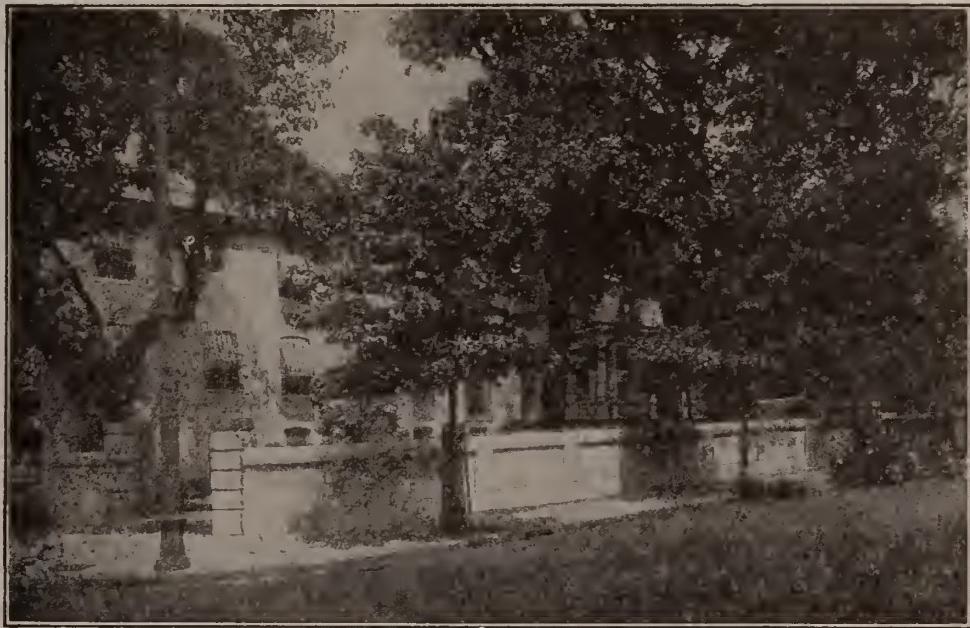
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years the Company has made a very rapid growth, several departments being required to expand output many times. All of these have been under the direction of Dr. Adams, as well as such new projects as the production of penicillin which will soon be housed in an entirely separate building equipped to increase production 30 times the present output. Because of Mr. Patterson's training as a chemical engineer, his broad executive experience, and wide acquaintance in the drug trade, he was called on to fill this position.

#### WHAT EVERY WOMAN DOESN'T KNOW —

##### HOW TO GIVE COD LIVER OIL

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silverplated spoon (particularly if the plating is worn), a glass spoon has an advantage.

On account of its higher potency in vitamins A and D, Mead's Cod Liver Oil Fortified with Percomorph Liver Oil may be given in about one-fourth the dosage of ordinary cod liver oil, and is particularly desirable in cases of fat intolerance.

#### COMBAT REPORT PRAISES B&L BINOCULARS

In a telegram addressed to the men and women of the Bausch & Lomb Optical Company, Rear Admiral W. B. Young, Chief of the Navy Bureau of Supplies and Accounts, transmits a combat report from an air squadron of the *USS Card*. This "baby flat-top," with her escort ships, has been honored with a presidential unit citation for sinking more enemy submarines than any similar team in Naval history.

The report from the *Card* read: "B&L binoculars were used constantly and were valuable even in bad weather. We wish the people who make them could have 'sighted suhs' through them as we did. They certainly helped us to 'sink same.'"

Says Admiral Young, "More of your fine optical equipment is urgently needed for new ships soon to join the fleet. Keep it coming."

#### A NEW SPECTACLE FRAME

American Optical Company announces a new special eye shape zylonite frame. Due to its anticipated popularity among both men and women, the frame has been named the *Sibling*—which means brother and sister.

The *Sibling*'s smart design is unusual without being radical or in bad taste. The frame blends with the contour of the face and so should appeal to women. The upper eyewire follows the upsweep of the eyebrows, while the lower eyewire follows the flare of the nose and the curve of the cheek. The *Sibling*'s extra lens length and its specially comfortable fitting properties should also appeal to men.

In addition to the high quality of its materials and workmanship, the *Sibling* offers several desirable fitting advantages. The angled design of the bridge and the lower eyewire will enable practitioners to fit the *Sibling* to many people who cannot be as well fitted with regular zylonite styles.

The *Sibling* is stocked in pink crystal, with regular hinge and two round rivets, in two eye sizes.

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Of course, he's fighting for much bigger things too—Freedom, and Democracy, and Lasting Peace.

But when he thinks of his return, it's the *little* things he looks forward to.

It happens that to many of us these important little things include the right to enjoy a refreshing glass of beer or ale . . . as a beverage of moderation after a good day's work . . . with good friends . . . with a home-cooked meal.

A glass of beer—not of crucial importance, surely . . . yet it is little things like this that help mean home to all of us, that do so much to build morale—ours and his.



Morale is a lot of little things  
(As you, Doctor, know better than most)

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**POLK COUNTY AUXILIARY**

The November meeting of the Woman's Auxiliary to the Polk County Medical Society was held in the Masonic Temple. A delicious chicken dinner was enjoyed after which a business session was held, with the president, Mrs. W. F. Peacock, presiding.

Plans were made for the activities of the auxiliary for the ensuing year. Announcement was made that the December meeting, to be held in Lakeland, would be in the form of a social honoring the wives of doctors at the Bartow Air Base and Drane Field as well as auxiliary members whose husbands are now in service.

Those present were Mrs. W. L. Tillis, Mrs. R. L. Cline, Mrs. John Wilson, Lakeland; Mrs. B. Y. Pennington of Lake Wales; Mrs. Peacock, Mrs. James G. Gilchrist, Mrs. C. H. Murphy, Bartow, and Mrs. Smith of the Bartow Air Base.

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### SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Eugene G. Peek, Ocala .....	Shaler Richardson, Jacksonville.....	St. Petersburg, Apr. 13-14, 1944
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville....	" " "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach....	" " "	Miami, Postponed
American Medical Association.....	James E. Paullin, Atlanta, Ga.....	Olin West, Chicago .....	Chicago, June 12-16, 1944
Southern Medical Association .....	W. T. Wootton, Hot Spgs., Ark.....	Mr. C. P. Loranz, Birmingham.....	November, 1944
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	Montgomery, Apr. 18-20, 1944
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta .....	E. D. Shanks, Atlanta.....	Savannah, May 9-12, 1944
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg....	Kenneth Phillips, Miami.....	St. Petersburg, April 13, 1944
Basic Science Exam. Board .....	M. W. Emmel, D.V.M., Gainesville	J. F. Conn, Ph.D., DeLand .....	Gainesville, June 8, 1944
Dental Society, State.....	E. C. Lunsford, D.D.S., Miami .....	H. L' Cartee, D.D.S., Miami .....	
Derm. and Syph., Soc. of.....	Wiley M. Sams, Miami.....	Lauren M. Sompayrac, Jacksonville	St. Petersburg, April 13, 1944
East Coast Medical Association.....	T. C. Kenaston, Cocoa .....	I. M. Hay, Melbourne.....	Postponed
Hospital Association.....	Mr. W. E. Arnold, Jacksonville .....	Miss Katharine Moyer, Lake Wales .....	St. Petersburg, April 13, 1944
Industrial Surgeons, Assn. of.....	Frank D. Gray, Orlando .....	A. M. Bidwell, Tampa .....	Jacksonville, June 26, 27, 1944
Medical Examining Board .....	I. W. Chandler, Avon Park .....	W. M. Rowlett, Tampa .....	
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville .....	Chairman .....	
Nurses Association, State.....	Miss Florence Jones, Jacksonville .....	Miss Madalee Hazel, Limona .....	
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville .....	C. E. Dunaway, Miami .....	St. Petersburg, April 13, 1944
Pathological Society.....	L. Y. Dyrenforth, Jacksonville .....	Iva C. Youmans, Miami .....	To Be Announced
Pediatric Society.....	Ludo von Meysenbug, Daytona B.	Robert Blessing, Ft. Lauderdale .....	To Be Announced
Pharmaceutical Association, State.....	Mr. H. B. Douglas, Bonifay .....	Mr. R. Q. Richards, Ft. Myers .....	Miami, To Be Announced
Public Health Association.....	Leland H. Dame, Sanford .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	John N. Moore, Ocala .....	Walter A. Weed, Orlando .....	To Be Announced
Railway Surgeons' Association .....	Frank D. Gray, Orlando .....	W. C. Page, Cocoa .....	
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales .....	Mrs. May Pynchon, Jacksonville .....	
Chattahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine .....	Robert B. McIver, Jacksonville .....	Postponed
Gulf Coast Clinical Society.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	Postponed
E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola .....	Kenneth Phillips, Miami .....	
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta .....	Postponed
Waukegan River Medical Society.....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City .....	

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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR	
				Total	Paid		
A	Bay	J. Powell Adams, M.D. Panama City	J. O. Barfield, M.D. County Health Unit Panama City	13	4	A-1-45 C. D. Whitaker, M.D. Marianna	
	Escambia *Santa Rosa	J. K. Turberville, M.D. Century	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	48	16	
	Franklin-Gulf		J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	6	1	
	Jackson *Calhoun	R. N. Joyner, M.D. Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	1	
	Walton-Okalooosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. Deluniake Springs	3rd Thursday 8:00 P.M.	6	0	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	1	
	Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	1	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	James W. Sapp, M.D. Havana	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 8:00 P.M.	40	11	
	Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		7	3	
	Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	G. H. Warren, M.D. Perry	Last Friday 8:00 P.M.	4	0	
B	Alachua *Brodford, Gilchrist, Union	Geo. C. Tillman, M.D. 505 W. University Gainesville	Chester F. Ahmann, M.D. 1043 W. Masonic Gainesville	2nd Wednesday 7:30 P.M.	26	8	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
	Duval *Clay	J. G. Lyerly, M.D. 514 Greenleaf Bldg. Jacksonville 2	O. E. Harrell, M.D. 712 Laura St. Jacksonville 2	1st Tuesday 8:15 P.M.	195	77	
	Marion *Levy	Robbins Nettles, M.D. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	26	15	
	Nassau	Geo. A. Dame, M.D. Fernandina	E. F. Waite, M.D. Fernandina	2nd Wednesday 8:00 P.M.	9	1	
	Putnam	J. Worth Brantley, M.D. Grandin	C. M. Knight, M.D. Palatka	2nd Tuesday Even Months 7:00 P.M.	9	2	
	St. Johns	Alfred W. Norris, M.D. Flagler Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	4	
	Brevard	G. E. Christie, M.D. Box 151 Titusville	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	2	
	Lake *Sumter	Louis R. Bowen, M.D. Eustis	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	8	
	Orange *Osceola	Duncan McEwan, M.D. 106 E. Central Ave. Orlando	Albert C. Kirk, M.D. 823 E. Colonial Dr. Orlando	3rd Wednesday 8:00 P.M.	90	35	
	Seminole	Samuel Puleston, M.D. Brumley-Puleston Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	13	5	
C	Volusia *Flagler	T. H. Dillard, M.D. DeLand	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	43	17	B-4-44 D. T. McEwan, M.D. Orlando
	Hillsborough	R. S. Torbett, M.D. 814 First Nat. Bk. Bldg. Tampa 2	Charles M. Gray, M.D. 306 Citizens Bldg. Tampa 2	1st Tuesday 8:00 P.M.	106	34	
	Manatee	M. M. Harrison, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	14	4	
	Pasco-Hernando- Citrus	S. C. Harvard, M.D. Brooksville	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	11	100%	
	Pinellas	J. A. Hardenbergh, M.D. 404 Power & Light Bldg. St. Petersburg 5	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg 4	1st and 3rd Fridays 6:30 P.M.	104	69	
	Sarasota	O. II. Cribbins, M.D. 138 N. Link Sarasota	A. O. Morton, M.D. Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	19	9	
	DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	4	
	Lee *Collier, Hendry	M. F. Johnson, M.D. Box 1266 Fort Myers	W. A. Harrison, M.D. 1029 First St. Fort Myers	3rd Tuesday 7:30 P.M.	17	100%	
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	Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	E. W. Stephens, M.D. 910 Harvey Bldg. W. Palm Beach	4th Monday 8:00 P.M.	64	18	
D	St. Lucie- Okeechobee-Indian River-Martin	Francis A. Gowdy, M.D. Box 745 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	6	C-5-44 Leland F. Carlton, M.D. Tampa
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	Dade	H. L. Pearson, M.D. 416 Ingraham Bldg. Miami	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami	1st Tuesday 8:30 P.M.	344	141	
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MARCH, 1944

No. 9

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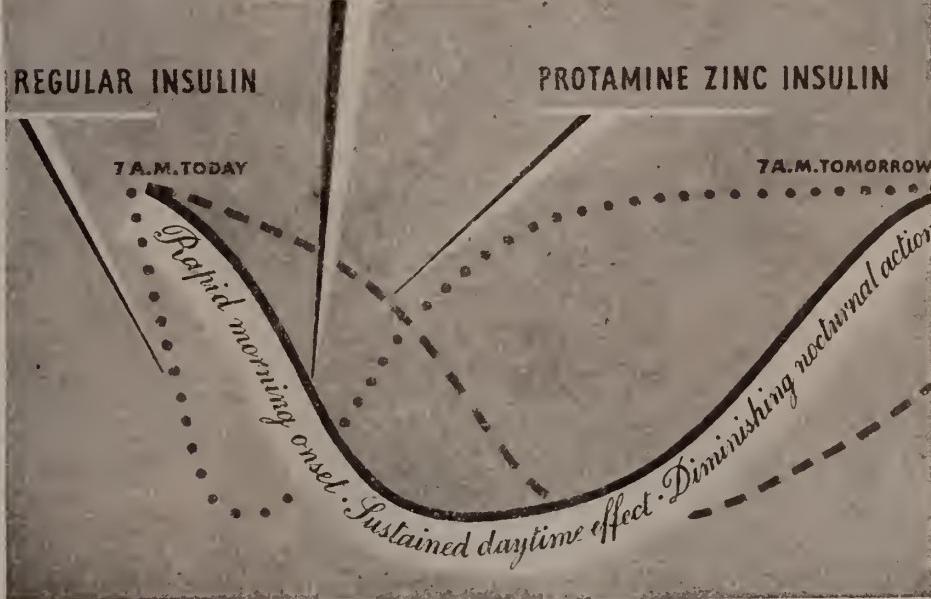
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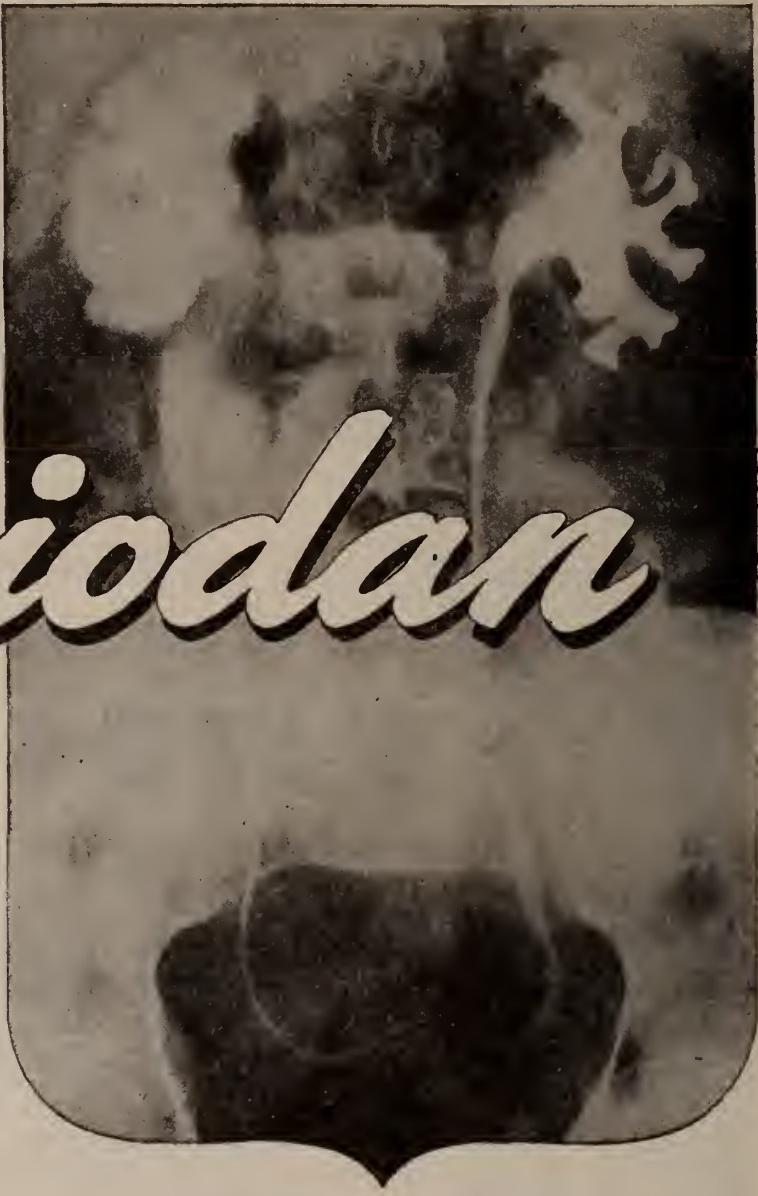
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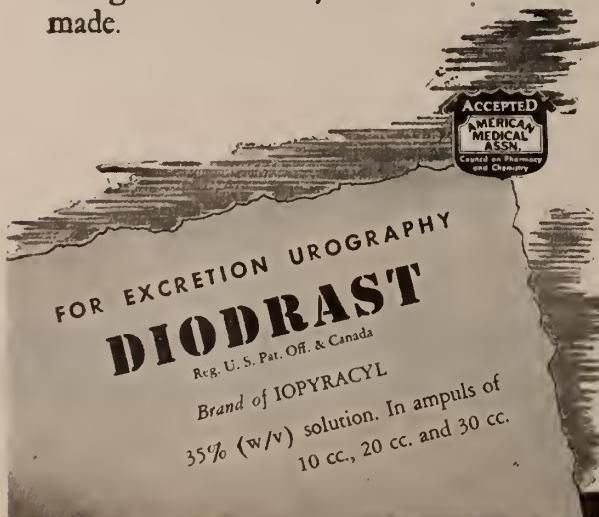
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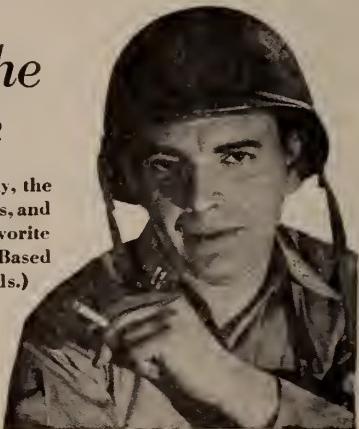
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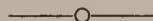
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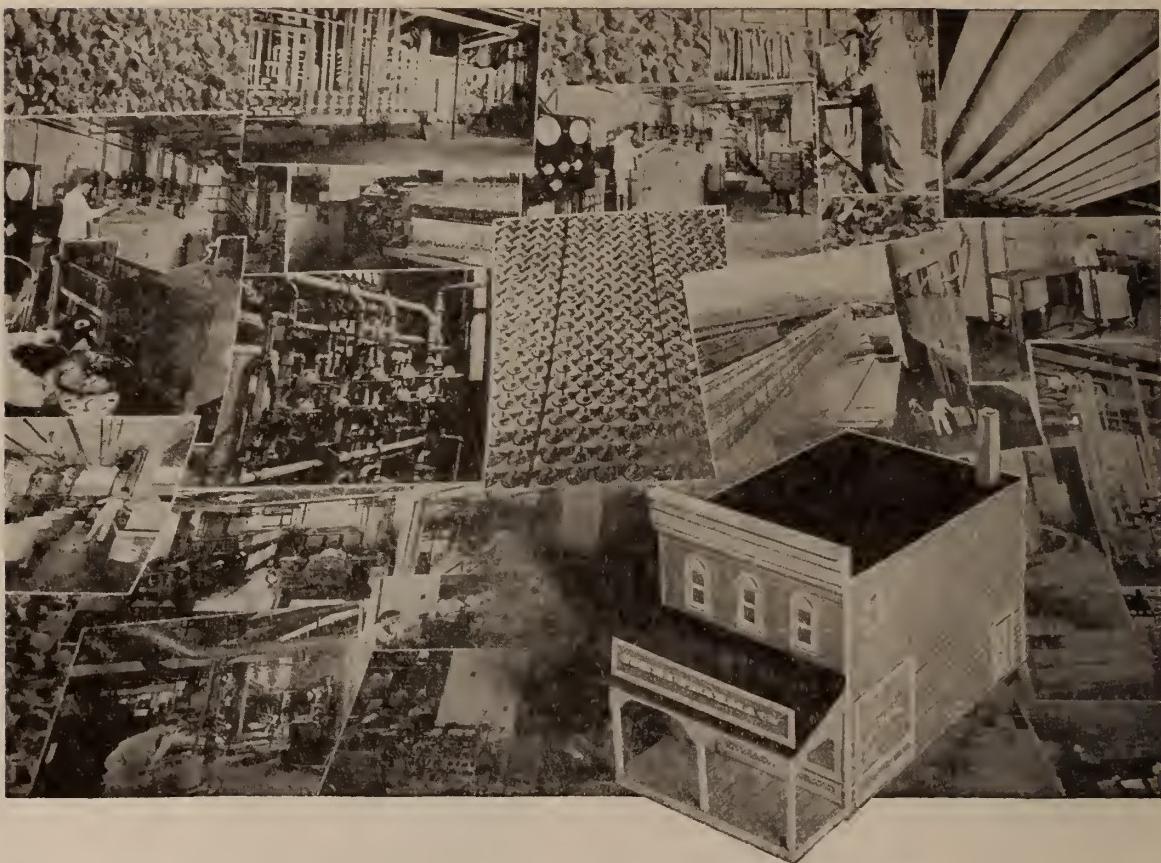
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XXX

Jacksonville, Florida, March, 1944

No. 9

## THE MODERN CONCEPT OF TUBERCULOSIS

ARTHUR J. LOGIE, M. D.  
MIAMI

Although tuberculosis has afflicted mankind for centuries, even today many of its aspects lack clear definition. A view of this disease over the years reveals that it is rampant during periods of stress and strife, and quiescent in times of peace and prosperity. As a result of this second World War, the mortality rate of tuberculosis has greatly increased in many parts of the world. In Scotland, the death rate from the disease is 33 per cent higher than it was the year prior to hostilities, while in Hong Kong there were approximately 6,000 deaths in 1940 compared to 4,000 in 1939.

In this country, in 1900 the tuberculosis death rate in the United States rose 15 per cent. In 1940. During the first World War the mortality rate in the United States rose 15 per cent. Today the downward trend has slowed up considerably, and a great increase is anticipated. The public is affected by the increased tension and the deprivations necessarily imposed during a war time regimen. Lowering of resistance through malnutrition, overexposure in bombproof shelters, rationing of food and clothing, and the acceleration of industry leading to mass migration to and from crowded quarters in industrial districts favor infection with and the spread of tubercle bacilli. At present, 1 per cent of selectees is rejected on account of tuberculosis at the induction centers, and an equal percentage is turned down for this reason by the local draft boards.

During the last few decades, there was an extraordinary reduction in the mortality caused by the disease, so much of one, in fact, that a great deal was said of the eradication rather than the control of tuberculosis. How much this reduction was influenced by antituberculosis programs, improved social and economic factors, and the wavelike movement of the epidemic cycle of the disease is difficult to estimate. Certainly, increased medical knowledge has had a leading role in this reduction. Today, tuberculosis is still the leading cause of death in the 15 to 45 year age

group, but more deaths occur from the disease in persons between 60 and 70 years of age than in any other age group. At present, for each death 2 new cases are reported to health departments. It is estimated that there are at least 5 clinically active cases for each death. The disease flourishes where unfavorable socioeconomic conditions exist.

Tuberculosis is not inherited. Congenital tuberculosis is a rare condition. Several cases have been reported in the literature in which infection reached the fetus via the placenta, or by means of aspiration or ingestion. As respiratory effort may occur prior to parturition, the fetus may become infected by aspirating liquor amnii containing tubercle bacilli. In the majority of cases, the placenta apparently acts as an efficient filter, and although a tuberculous bacillemia may be present in the mother, usually no bacilli pass through to reach the developing child by means of the blood stream. Tuberculosis is essentially a family disease, spreading from one member of the household to another because of the prolonged and intimate contact that takes place in the home. Many believe that resistance to the disease is inherited and may be handed down from one generation to another in increasing strength. This theory would explain the low death rate among Jews in contrast to that of the Negro race. Negroes have not reached an equal stage of tuberculinization for their contact with the tubercle bacillus is of comparatively recent origin. Their lack of resistance to progressive disease is notorious; hematogenous spread occurs two and a half times more frequently than in white persons.

In 1882, Koch, by identifying the tubercle bacillus, established for all time the essential cause and unity of tuberculosis. In this country, tuberculin testing of cattle and nationwide pasteurization of milk have almost completely eliminated the bovine type as an important pathogen to man. The incidence of pulmonary tuberculosis caused by the bovine bacillus may rise to 4 per cent. Abroad, bovine tuberculosis is a rather frequent condition, particularly in children. Recently attention was directed to the possibility of the production of tuberculosis, through the transmission of the avian bacillus from fowl to man.

Because of the elusiveness of the disease, the tubercle bacillus has been studied more intensively than any other organism. It has been split into chemical fractions; the lipid fraction which causes tubercle formation, and the protein fraction which produces tuberculoallergy. No longer is the physician satisfied with a laboratory report of acid-fast bacilli, knowing that they occur everywhere and that the majority of them are non-pathogenic. He realizes now that the tubercle bacillus has no waxy coat, but that the lipid scattered throughout the body of the organism in the form of mycolic acid explains its acid-fast staining property. He is also aware of the fact that young tubercle bacilli pass through a stage during which they are not acid-fast, and may be the cause of unusual variations of the disease such as sarcoidosis and uveoparotid fever. The bacilli may occur in the granular form; in this form they are, however, not considered true variants, but merely phases of development. Many physicians have been confused by the persistent absence of the organism in cases in which the syndrome is otherwise characteristic of tuberculosis. Investigation suggests the possibility of involutional forms of the bacillus having ultra-microscopic and filtrable properties.

Within recent years, bacteriologists have dissociated the tubercle bacillus into two components, the rough colonies which are usually non-pathogenic and the smooth colonies which are virulent disease producers. They have observed that one or the other develops, depending upon favorable conditions. This biphasic feature of the bacillus has been the chief argument against the use of the BCG vaccine for immunization against tuberculosis. In Europe and South America, BCG vaccination of children from tuberculous families, student nurses and medical students appears to be giving favorable results. In this country, however, Petroff<sup>1</sup> demonstrated that cultures of BCG, which consist of attenuated bovine bacilli, may undergo variation and can be made to dissociate the smooth form of organism, thereby converting the vaccine into a dangerous infecting agent.

Eight years after the discovery of the tubercle bacillus, Koch introduced tuberculin as a specific remedy for the disease. As a therapeutic measure it has depreciated in value, although it is still used occasionally in high dilutions for tuberculous infections of the eye, skin and genitourinary system. The rationale for its therapeutic use is

based upon the focal and general reaction it causes, which may stimulate healing of the lesion, or desensitize the tissues and encourage the production of antibodies. The chief value of tuberculin lies in the problem of diagnosis, but even here its reliability has been questioned lately. At present, the Mantoux intracutaneous tuberculin test is the most accurate method of testing. Purified protein derivative tuberculin in two strengths has replaced old tuberculin as the latter produces pseudoreactions too frequently. The Vollmer patch test is gaining in popularity. It is a simple procedure consisting of the application of a plaster impregnated with a synthetic tuberculin to the skin, which has been cleansed previously with acetone. A negative patch test should be followed by a test with a stronger tuberculin such as PPD second strength. The tuberculin test is of greater value in young children and is being used for adolescents and adults more frequently, as many young people are now reaching the adult stage without ever having had a primary infection. No longer is it true that in over 90 per cent of adults there is a positive reaction. In Florida, of 760 adults tested with PPD in two strengths, only 59 per cent showed a positive tuberculin reaction.

How much confidence can be placed in the tuberculin test is questionable in the face of recent findings. It is known that in certain conditions, particularly the acute exanthemas, it elicits no response, but several observers have reported its failure in ordinary cases of active tuberculosis. Sensitivity to tuberculin usually fades with healing of the lesion, and anergy exists when the bacilli in the body are no longer viable. In view of these dictums, the belief that once the tuberculin test is positive, it will always remain so, is no longer tenable. It is also known that a small percentage of persons in whom characteristic calcified lesions are demonstrated roentgenologically do not react to the test. The amount of tuberculin used for skin testing purposes, even if repeated testing is done, does not sensitize the tissues, although retesting may awaken a pre-existing sensitivity too slight to respond to a single test. It has been reported that tuberculin in testing doses may light up latent foci of malaria.

The pathogenesis of tuberculosis presents a somewhat complex picture. The first time the tubercle bacillus enters the body, the tissues are sensitized, that is, tuberculoallergy is established;

a type of pulmonary tuberculosis develops which is usually benign; it may occur in children or adults. This is the first infection type of tuberculosis, formerly designated the childhood type. Whether primary tuberculosis in adults is more benign or more malignant than the primary lesion in children is a debatable issue. As the lesions in adults tend to soften and ulcerate sooner than those in children, a progressive primary complex is more apt to occur. There is less glandular involvement and less calcification in adults. A reinfection with the bacillus finds the tissues allergic to tuberculin-protein and results in a reaction which differs from the primary infection; extensive destruction of tissue occurs. This is known as the reinfection type of tuberculosis, formerly called the adult type.

The manner in which the reinfection type of tuberculosis arises is not clear. One is informed that of the two modes of reinfection, the exogenous route is the commoner, and that bacilli entering from without may establish lesions in the body or give off a tuberculin-like substance which reactivates old foci of the primary infection. One is also informed that, following the first infection, the bacilli may be enveloped in a calcified matrix, may remain viable for as long as twenty years, may escape at any time from the nodule and may then possibly set up an endogenous reinfection type of tuberculosis. The majority of European workers believe that the endogenous route of reinfection is of more frequent occurrence and that the exogenous mode is of relatively little importance in reinfection.

The question of allergy and immunity in tuberculosis remains a debatable one. Six weeks after the tubercle bacillus makes its initial entrance into the body, the tuberculin test will give a positive reaction indicating that allergy has been established. Some believe that allergy cannot exist without the presence of immunity and that it is possible to reduce the allergy without affecting the immunity. Others disagree with this belief and say that allergy is definitely harmful and that it can and does exist alone.

Allergic tissue reacts to invasion by tubercle bacilli in a manner similar to virgin tissue, except that the reaction is far more rapid and acute. The first pathologic change consists of exudation, and within a few hours the organisms become surrounded by polymorphonuclear leukocytes, which soon succumb to the toxic action of the bacilli. Monocytes and lymphocytes then rush

to the rescue and, with the appearance of the mononuclear cells, productive changes take place. The lymphocyte-monocyte ratio has been utilized to determine the progress of the condition. Greater prognostic significance is, however, attached to serial studies of the leukocytic index.

If the protective forces of the body are strong enough to cope with the infection, the exudate will be resorbed, and the process will be localized by encapsulation, fibrous replacement, calcification, or ossification. If the resistance is insufficient to control the infection, caseation occurs, and the caseous material eventually drains into a bronchus, leaving an excavation at the original site. By means of bronchogenic spread or hematogenous metastases, the disease is carried to other portions of the lung and to other parts of the body.

So long as a tuberculous cavity in the lung remains patent, the patient will of course have an active case and will cough up bacilli. In only 40 per cent of cases is the cavity seen on the roentgenogram. Less than 10 per cent of these cavities can be diagnosed with the stethoscope. Occasionally, one is puzzled by the sudden disappearance of cavities. The behavior of these caverns depends upon the obstructing mechanism of the draining bronchus. If a ball valve or check valve obstruction exists, the cavity may grow larger or smaller almost before one's eyes, or it may be visible on a roentgenogram today and invisible on one taken a few days later.

Many physicians have been inclined to view pulmonary tuberculosis as a condition pathologically conforming to one classical description. It is evident, however, that in reinfection tuberculosis, the type of lesion that develops in the lungs depends upon the dosage and virulence of the infecting organisms and the resistance and immunity of the host. The lesion may be exudative, caseous pneumonic, or proliferative in type, depending upon the tissue reaction which predominates. When the tissues are hyperergic and the dosage of organisms is large or of a high virulence, the caseous pneumonic type will probably develop. If the tissues have a low degree of allergy, the chronic proliferative or fibroid type will probably ensue. No diagnosis of pulmonary tuberculosis is absolute until the tubercle bacillus has been demonstrated; but one should not wait for the discovery of the organism before arriving at a tentative diagnosis and instituting precautionary and therapeutic measures.

The roentgen examination has surpassed by far all other means of diagnosing the disease. Mass radiography is the indispensable feature of every antituberculosis program. Some health departments employ the rapid x-ray unit with paper films in rolls. Others depend upon fluoroscopy followed by the use of celluloid films when necessary. Fluorography, or photography of the fluoroscopic image on 4 by 5 inch or 35 mm. films, is now being utilized. Roentgenography reveals early lesions in the chest from two to three years before the characteristic symptoms of tuberculosis appear. Single flat films of the chest are suitable, but stereoscopic plates are preferable when the lesions are complex, multiple, or superimposed. Lesions can be orientated and the depth determined, but stereoscopy usually reveals few lesions which cannot be seen in the flat film. (Flat film, PA, visualizes about 75 per cent of the lungs with an error of less than 0.4 per cent as compared to stereoscopy.) Frequently, the lesion is concealed in the mediastinal shadows, necessitating lateral, oblique, or lordotic views. It takes from two to four years for calcification to become manifest radiographically.

When a roentgenogram of the chest gives negative evidence of pathologic change but there are bacilli in the sputum, bronchoscopy often reveals tuberculous involvement of the trachea or bronchi. It is well to suspect a tuberculous bronchitis or tracheitis in a patient who suffers from asthmatoïd wheezing and frequent spasms of violent coughing, and who expectorates copious sputum. Although a roentgenogram of the chest usually shows no lesion in the lung fields, bronchoscopy, however, reveals the true story. Bronchograms can be satisfactorily produced with a watery contrast medium. Diodrast penetrates small bronchial channels better and causes less irritation than an oily medium such as lipiodol. For detailed study of lesions of the chest, particularly cavities, laminagraphy is of great value. Laminagraphy or tomography is body-section radiography, a roentgen examination whereby a particular section, plane or layer can be visualized with more or less exclusion of other structures. For special study of mediastinal shadows, hilar angiography has been employed with 70 per cent diodrast. By this method the vascular structures of the hilum and mediastinum can be visualized.

In the diagnosis and prognosis of pulmonary tuberculosis, repeated examinations of the sputum are essential. A concentrated specimen collected

over a period of from two to four days may be necessary, or sputum cultures and guinea pig inoculations may be required. Fluorescent microscopy reveals more tubercle bacilli than any other method of examining the sputum. The bacilli stained with carbolauramine are viewed through ultraviolet light. Guinea pig inoculation by the intracutaneous or intratesticular route gives results in from seven to twenty-one days. If no sputum is obtainable, examination of the gastric contents by the concentrate method should be made as tubercle bacilli may pass through fibrous tissue in the lungs and may escape prior to cavitation or from imperfectly healed areas. As patients unconsciously swallow sputum through the night, gastric lavage before breakfast will supply an excellent specimen for laboratory examination. It is well to remember that pleurisy with effusion is usually tuberculous in origin and should be treated as such by prolonged bed rest. The underlying lung should be visualized by drawing off some of the fluid.

The prognosis of a case of tuberculosis can be ascertained by serial roentgenograms of the chest, repeated blood sedimentation tests and repeated studies of the leukocytic index. In active tuberculosis the blood platelets show a thrombocytosis. If a thrombocytopenia with increase of megalothrombocytes occurs, the prognosis is considered unfavorable. The prognosis depends to a great extent upon the type of tuberculosis in the lungs. The patient with the exudative type usually recovers; the one with the caseous pneumonic lesion requires immediate and prolonged collapse therapy; the one with the proliferative or fibroid type dies eventually of some complication or superimposed condition.

The prognosis in cases of pulmonary tuberculosis has not been improved for the individual patient in the last twenty years, in spite of the reduction in the mortality and morbidity rates for the general population. Today, the disease develops in fewer persons, but the proportion of fatalities is the same as in 1915. The reason is not that the treatment is unsound, but that patients do not receive treatment soon enough. Even at the present time in the great majority of cases the presence of the disease is not discovered and the patient is not subjected to curative treatment at a sufficiently early stage to make this treatment effective. In less than 20 per cent of the cases reported to health departments or admitted to sanatoriums has the dis-

ease been diagnosed at a minimal stage. Although pneumothorax is extensively used, it can hardly be said that it is employed skillfully by more than a minority of those who work in the field. Unfortunately, too few physicians realize the futility of continuing pneumothorax when the sputum remains positive after from three to six months of such treatment. After a few months, pleural adhesions form, and a thick fibrous wall grows around the cavity, precluding its closure. In such cases, pneumothorax should be discontinued and other methods of collapse tried. Many times the physician is guilty of needless delay before considering surgical intervention, such as pneumolysis or thoracoplasty.

In the treatment of tuberculosis, climate no longer receives serious consideration. No longer does the physician employ sunshine when treating active cases. Rather than overtax an already weakened digestive system with an overabundance of milk and eggs, he prescribes, for the average patient, a regular diet of from two to three thousand calories with a high vitamin content. Since the discovery that in cases of tuberculosis there is a deficiency of vitamins A, C, and K which can be compensated for by exact dosage, these are given routinely. Vitamin K also raises the prothrombin level, which is depressed by tuberculotoxemia, and so prevents repeated hemoptysis. At Saranac Lake, a chilled mixture of orange or tomato juice and plain cod liver oil administered daily has inhibited the development of the formerly frequent complication of intestinal tuberculosis. Recently, the excellent therapeutic results obtained in tuberculous guinea pigs with the use of promin, a sodium salt of dextrose sulfonate, hold great promise for the future.

A lung which under normal conditions contracts and expands at the rate of 28,000 times per day must be put at rest when it is diseased. To avoid alterations in the hydrogen ion concentration and the carbon dioxide content of the blood which will further increase the respiratory rate and tissue metabolism, mental as well as physical rest is important. Temporizing too long before collapsing the lung is a dangerous procedure. It is worth while attempting pneumothorax in every case. It will control the early lesion before cavitation has occurred. Even the lung with a considerably advanced lesion will occasionally collapse most satisfactorily.

The greatest weapon in the fight against tuberculosis is collapse therapy. Artificial intrapleu-

ral pneumothorax is not only the choice method of therapy in pulmonary tuberculosis but also a useful diagnostic procedure in the differentiation between extrapulmonary and intrapulmonary conditions. Pneumothorax collapses the lung, relieves the tension of the diseased areas, expresses retained secretions and produces local rest, ischemia and lymphatic stasis. It distorts the bronchial channels so that the air which the bacilli require for growth cannot enter the diseased areas, and reduces the intracavitory pressure, which favors closure of cavities. The best index that pneumothorax is accomplishing its purpose is conversion of the sputum from positive to negative.

The majority of phthisiologists have found it best to administer 150 to 200 cc. of air at the initial pneumothorax induction. The first and second refills should be given at twenty-four hour intervals, with the administration of about 200 cc. of air. Then, similar refills are given every other day. Thereafter, the amount of air and the frequency of refills are gauged by repeated fluoroscopic examination and manometer readings. Excellent results are obtained by small but frequent refills. Artificial pneumothorax should be continued for at least two years before reexpansion of the collapsed lung is considered. The pneumothoracist must be familiar with the complications of the procedure. In about 30 per cent of cases pleural effusion develops. If the disease spreads to the contralateral lung of a patient receiving unilateral pneumothorax, bilateral pneumothorax may be instituted. When a patient is at absolute bed rest, the reduction in vital capacity due to bilateral pneumothorax is slight. Actually, in quiet breathing, a person uses only from one twentieth to one tenth of the parenchyma of the lung. In cases of bilateral pneumothorax, the patient who manages one year free of complications as a rule will do well for the future. In a large percentage of cases of pneumothorax pleural adhesions occur which have to be severed by intrapleural pneumolysis before the cavities can be successfully closed.

If pneumothorax is unsuccessful, thoracoplasty should be considered while the patient has fairly good general resistance. The thoracoplasty may be partial or complete, depending upon the site and the extent of the lesion, and the volume of the remaining healthy lung. Bilateral thoracoplasty is effective if there is the equivalent of two healthy lobes remaining. With specific lung mobilization and subtotal scapulectomy, the deformity and

disability following the operation are hardly noticeable. Postoperative pain in the chest can be relieved by procaine paravertebral block of the thoracic and lumbar segmental nerves.

Pneumoperitoneum has a definite place in the treatment of pulmonary tuberculosis in extensive bilateral disease, especially when the vital capacity is so limited and the toxicity so great that no other type of collapse seems warranted. It is also indicated in women following a pregnancy and when pneumothorax cannot be established. The relief and improvement that tuberculous women experienced during pregnancy due to the increased intraabdominal pressure had much to do with the use of pneumoperitoneum today. It is usually employed in conjunction with phrenic nerve block. The enormous rise of the diaphragm exerts a beneficial pressure upon the diseased lung from below. The procedure is similar to a pneumothorax induction or refill. Pneumoperitoneum is much more effective than phrenicoexeresis alone as it produces a much greater rise of the diaphragm.

In cases in which pneumothorax is impossible because of massive pleural adhesions and thoracoplasty is contraindicated, an extrapleural pneumothorax may be instituted. This is done by incising along the spinal edge of the scapula and by blunt dissection down to the parietal pleura of the lung. The lobe of the lung and its pleurae are freed of all their attachments until a satisfactory space is formed. This is the extrapleural space. The space is then irrigated with saline, and the wound is closed. After twenty-four hours, enough air is injected into the space to give a slightly positive pressure. This keeps the space open and prevents bleeding. A refill is given the next day, with the administration of 150 cc. of air. Thereafter, fluoroscopy determines the amount to be given. The amount of air which can be given at subsequent refills decreases gradually. An extrapleural pneumothorax is often used as an adjunct to an intrapleural pneumothorax in order to obtain a satisfactory collapse of the diseased portion of the lung with its adherent pleurae. The complications which may arise are empyema of the space and hemorrhage from an intercostal artery.

In large thick-walled cavities where thoracoplasty cannot be considered, the Monaldi treatment may be of value. This consists of prolonged suction aspiration of the tuberculous cavity by transthoracic puncture (transpleural decompression).

A rubber catheter is passed through the chest wall and inserted directly into the cavity for the purpose of creating a negative pressure, draining the cavity and closing the leading bronchus from within. Later, thoracoplasty will insure permanent closure.

When one is treating a patient with tuberculosis, due consideration should be given to rehabilitation. Over 40 per cent of the patients discharged from sanatoriums have a recurrence of the disease within five years after discharge. The patient who has not been institutionalized long enough, whose treatment has been discontinued too soon, or who has resumed his former occupation too early will doubtless suffer a relapse.

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#### VITAL STATISTICS COMPILED IN KEY WEST DURING 1835

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One hundred and eight years ago the citizens of Key West, Fla., became cognizant of the paucity of facilities for medical care in the community. Also, it was apparent that people on the continent believed the locality to be unhealthful. The situation discouraged the coming of outsiders to this island settlement to convalesce and to trade. Prior to 1835 a few medical records had been sent to Washington, D. C., by the Army and Navy. The information contained in these communications was, however, limited to conditions among the armed forces stationed on the island. For the purpose of evaluating public health conditions and of disproving the idea of medical insecurity in the town, J. R. Mallory, a private citizen, submitted some vital statistics covering the period from 1829 to 1834, and the editor of the local newspaper, *The Key West Enquirer*, published discussions on these subjects. These meager reports probably represent some of the oldest public health studies preserved in Florida. For this reason this dissertation is given.

Compilations are for the years 1829 to 1835 inclusive. Table 1 shows the number of deaths per year, arranged according to sex, age, race and

residency. The outstanding result by breakdown of the figures discloses a large number of nonresident fatalities (76, or 46 per cent). Instability of the population was contributory to spread of disease for decades before and after this era. Newcomers to the isle occasionally acted as carriers of communicable diseases from foreign ports. Examples demonstrating this relationship can be found in a study of the smallpox and yellow fever epidemics, which occurred there before the beginning of the twentieth century.

There was no apparent racial difference in death rates. Twenty-two per cent of the total mortality occurred among the Negroes in the period studied. This percentage corresponded roughly to the ratio found in the population, which was 517 with 144 Negroes included in 1829 and about 600 by 1835.

TABLE 1.—Number of Deaths in Key West, Fla., from 1829 to 1835 Inclusive

	1829	1830	1831	1832	1833	1834	Total
Females	16	4	3	4	7	7	41
Males	33	10	18	18	20	23	122
Adults	43	12	18	19	24	20	136
Children	6	2	3	3	3	10	27
Whites	43	11	17	17	17	23	128
Negroes	6	3	4	5	10	7	35
Residents	27	4	15	8	19	14	87
Nonresidents	22	10	6	14	8	16	76
Total	49	14	21	22	27	30	163*

\*Only the total number of deaths is available for 1835. There were 13, making a total of 176 for the period.

It is reasonable to assume that these data, particularly the percentage of nonresident deaths, manifested the need for a hospital. In 1835 and 1836 the Key Westers petitioned the Congress through their territorial delegate in Washington to provide funds for construction of a unit where sick and injured seamen could be given medical aid. Eventually the United States Treasury appropriated money to erect a Marine Hospital in 1844. In the final authorization it was indirectly stated that physicians attached to the hospital could lend emergency care to the civilians. The story of this institution will be published elsewhere.

Causes of death are enumerated in table 2. The cause was ascertained for 146 of the 176 fatalities occurring during the seven years. A comment attached to part of the observations recorded read:

With only an exception the deaths from visceral derangements, without doing violence to truth, or injustice to the deceased, have been clasped with deaths from intemperance. More cases of slow suicide occur in this part of the world than the lovers of "Gunnison Holland's Brandy Cocktail" and "Mint Julep" would be ready to acknowledge.

Eight deaths from cholera are included in the table. In 1874 Dr. Robert Murray in a letter to the Director of the United States Marine Hospital Service said this disease had never appeared in Key West. He knew of ships that had anchored in the harbor having patients with the malady on board, but he claimed that ill persons were not allowed to disembark. He may or may not have been right for in those days differentiation from various fevers such as typhoid was not established as it is today.

TABLE 2.—Causes of Death in Key West, Fla., from 1829 to 1835 Inclusive

Cause of Death	Deaths	Total
Communicable Diseases and Acute Infections	69	
Fever: biliousness and remittent 30; intermit-	34	
tent 1; yellow 3		
Consumption	10	
Cholera	8	
Inflammation: of bowel 2; of brain 2;		
of stomach and throat, 1 each	6	
Chronic diarrhea and black vomit, 3 each	6	
Smallpox	3	
Measles and lockjaw, 1 each	2	
Violence and Intemperance	30	
Intemperance	10	
Casualty	7	
Drowned	6	
Hurt and gunshot wound, 3 each	6	
Hung	1	
Cardiovascular, Renal and Neoplastic Dis-	15	
eases		
Dropsey: general 3; of brain 2; of chest 2	7	
Apoplex	3	
Slow decay	2	
Ulcerated prostate gland, ulceration of		
aorta, and "supposed" cancer of		
stomach, 1 each	3	
Miscellaneous	32	
Visceral derangements	11	
Convulsions	6	
Marasmus	5	
Unknown	4	
Stillborn	3	
Teething, apathy and worms, 1 each	3	

Total

146\*

\*The causes were not available for 30 deaths.

Comparison of the principal causes of death listed for this period with those given on the death certificates of 413 of 432 patients dying in Monroe County during 1929 and 1931, nearly all of whom lived and died in Key West, revealed several interesting facts. Pathologic entities, such as neoplasms and renal and cardiac diseases seen ordinarily in the senescent, accounted for 10.3 per cent of the deaths (15 cases) in the early period as contrasted with 45.1 per cent in 1929 and 1931,

including 39 attributed to neoplasm, 33 to renal disease and 114 to cardiac disease. In the early series dropsical conditions were cited as the cause of death in 7 cases, ulceration of the prostate in 1 case and slow decay in 2 cases; these are dubiously considered geriatric maladies. Exclude them, and only 5 cases, or 3.5 per cent, remain in this category. Two explanations partially satisfy the variation at the beginning and the end of the century. In the early period the average age of survival was about one half of that in 1930. And, after World War I the island became more of a haven for the retired and decrepit.

Proportionately almost four times as many persons succumbed as a result of violence and intemperance in the first period, or 20.7 as opposed to 5.5 per cent. Communicable and inflammatory diseases were also doubly common, the figures being 47.2 as compared to 21.8 per cent.\* Tuberculosis tended to increase with growth of the population. In some of the recent years the rate was higher in this locality than anywhere in Florida with the exception of three counties. Poor sanitation, poverty and lack of adequate facilities among the Negroes and poorer class of white folk tended to keep up the mortality. In addition, a few Northerners came here to convalesce and subsequently died of the illness.

Incomplete birth records were available for 16 infants in 1834. One baby was stillborn.

\*89 cases (tuberculosis 30; pneumonia 21; influenza 9; septicemia 6; enteritis and colitis 4 each; enterocolitis and tetanus 3 each; meningitis 2; leprosy, pyemia gastrohepatitis, acute peritonitis, typhoid fever, anterior poliomyelitis and diphtheria 1 each).

## ABSTRACTS OF MEDICAL ARTICLES

FACIAL FRACTURES AS SEEN IN THE NAVAL SERVICE, LIPSCOMB, THOMAS H., JACKSONVILLE, SOUTH. M. J. 36: 665-668 (OCT.) 1943.

The procedure in the Naval Service incident to the handling of facial fractures is described. Following initial emergency treatment and preliminary clinical examination, the patient is allowed to recover from shock. A more thorough examination is then made for hemorrhage, fracture of the jaws as shown, for example, by malocclusion of the teeth or crepitus, and injury to the orbits as shown by diplopia or an irregularity of the orbital edges. Roentgen examination often includes the usual views of the skull and also Bucky-Waters occlusal and special views for zygomatic processes; in some cases oblique or body-section films are made.

Nine were Negroes, and 7 were white. Eight were females, 7 were males, and for 1 the sex was not recorded.

Other than the statistics already given, private and public discussions on the subject of the healthfulness of Key West were made. In December 1835, W. A. Whitehead, one of the organizers of the town, presented a brief story of the development of the settlement to John Rodman, Esq., of St. Augustine, Fla. He mentioned that yellow fever had not appeared since 1829; mosquitoes were, however, "most annoying." The statement concerning the ague is contradictory for the reason that in 1912 Dr. J. Y. Porter told of the first severe epidemic, which broke forth in 1835. His grandfather was one of the victims of the fever.

The most heated argument on the topic was published in the *Enquirer*. Testimony was based on Commodore Porter's report made in 1829. The communication explained the prevalence of disease among the naval personnel bivouacked in the town from 1822 to 1824. Porter wrote:

The malady with which the naval forces under my command for the suppression of piracy was afflicted, had its origin in the excessive severity of the duty performed, and the total absence of every description of comfort. The disease was contracted among the haunts of the pirates on the coast of Cuba and not as is generally supposed at Key West.

In conclusion, the editor was of the opinion that "living conditions are no different here than in any other southern port."

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The orthopedic surgeon, the eye, ear, nose and throat specialist, the dental officer and the radiologist confer regarding the extent of the injury and the plan of treatment. The treatment is directed toward obtaining satisfactory occlusion, satisfactory vision, drainage of hemorrhage or pus, and cosmetic result. The orthopedic surgeon, the eye, ear, nose and throat specialist, the dental officer and the anesthetist cooperate in attaining these objectives.

Illustrations show the various steps taken in caring for a flier who sustained a complicated injury in a crash. The paper is designed to emphasize the benefits derived from full consultation and group cooperation in meeting this difficult problem.

## LATE RESULTS FOLLOWING TRANSURETHRAL PROSTATIC RESECTION, ORR, LOUIS M.; KUNDERT, PALMER R., AND PYLE, FRANK J., ORLANDO, NEW YORK STATE J. MED. 43:521-524 (MAR. 15) 1943.

The authors have recounted their experiences in the use of transurethral resection as a method of relieving prostatic obstruction. Their study, covering a period of approximately ten years, was directed toward obtaining the true end results of prostatic resection in a group of 483 private patients receiving the advantages of good hospital and nursing care. Of the 407 traced, 115 had died, 252 sent intelligible replies to a questionnaire and of this number 209 presented themselves for examination. The results of the study are set forth in eight tables.

The surgical mortality was 8.3 per cent, higher than that usually reported for this method of prostatic surgery, notwithstanding careful attention to the most advanced operative technic and preparation of the patient. No patient was subjected to inhalation anesthesia and no complication or fatality could be attributed to the anesthetic.

Despite the hazards of surgical measures in the large number of patients advanced in years, many of them suffering from cardiac disease, hemiplegia, diabetes or general ill health, only 2 were refused transurethral resection. Because of the presence of these concomitant conditions any other type of prostatic surgery would probably have been considered too hazardous. Perhaps the most important conclusion resulting from this study was that by this method of surgical intervention a great many more patients with severe organic diseases were given the opportunity for the relief of urinary obstruction than would otherwise have been possible.

After several years, evidence of regrowth was observed in patients completely relieved of symptoms by complete resection. In those returning with obstructive symptoms years after the initial operation hypertrophy had invariably developed in that part of the prostate not originally treated surgically. Usually, in patients returning within a few months or a year because of incomplete relief, not enough prostatic tissue had been removed.

Persistent pyuria with resulting frequency, burning and nocturia was a disappointing after-effect in a large majority of the cases. Both pathologic and bacteriologic examination of the tissue removed indicated that the pyuria is caused far more frequently by remaining bits of infected

prostatic tissue than by infection introduced during or immediately after the operation.

It was noted that pathologic examination of practically every section of the tissue removed by resection is necessary in order to make a correct diagnosis and thus avoid overlooking evidence of incipient malignant disease.

The authors observed that the use of too large an instrument causes practically all of the strictures which occur following the operation and they concluded that most of them could be avoided if an operating instrument with a sheath no larger than 26 or 27 F in size were used.



## QUININE IN RELATION TO NERVE DEAFNESS, FORBES, S. B., TAMPA, ANN. OTOL., RHIN., &amp; LARYNG. 52: 109 (MAR.) 1943.

Quinine, a protoplasmic poison known to have a particular affinity for the auditory nerve and to be capable of causing nerve deafness, is described as a possible etiologic factor of this type of deafness that should receive greater attention in otology. Idiosyncrasy for the drug appears to be the determining factor in its administration and is regarded as an important consideration not sufficiently stressed in the etiology of nerve deafness.

Perception of the high tones is first affected. Because these tones are beyond the conversational range, the patient may be unaware of this initial manifestation of impaired hearing. In some instances when administered in large doses, quinine may apparently cause permanent impairment both of hearing and of vision.

Mention is made of experimental evidence and clinical observations which support the view that quinine administered to the mother during pregnancy may cause deafness and amblyopia in the child.

A series of 1,401 cases of all types of deafness is analyzed; 316 were cases of nerve deafness, and the remaining 1,085 cases included all other types of deafness. In 34.5 per cent of the cases of nerve deafness quinine was a significant factor while in only 8.5 per cent of the much larger group of cases of all other types of deafness was it to be considered.

Audiograms and charts of visual fields suggesting the role of quinine as a causative agent both of nerve deafness and amblyopia are presented. Also, evidence is offered which indicates that quinidine may be a cause of nerve deafness.

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**ANNUAL CONVENTION, ST. PETERSBURG**

This year the annual meeting of the Florida Medical Association will be held April 13 and 14, at the Princess Martha Hotel, St. Petersburg. Members and guests are urged to make their hotel reservations well in advance of these dates. A splendid program has been prepared, which will be of definite value to our members and guests even though the time allotted to it has been curtailed because of the war effort.

Dr. Edgar G. Ballenger of Atlanta, president-elect of the Southern Medical Association, will be the guest speaker at the first general session, Thursday, at 1:30 p.m., by invitation of President Peek. On Thursday evening at 8 o'clock four scientific papers will be presented by medical officers from MacDill Field. The essayists are able physicians who will present papers of unusual interest. On Friday at 10:30 a.m. three papers will be presented by notable physicians who will appear by special invitation. The scientific program has been carefully planned by the Association's Committee on Scientific Work, of which Dr. Herbert E. White is chairman, with the cooperation of the officers of the Association.

The meeting—streamlined to conserve the time of busy practitioners—will be one that few of our members will wish to miss.

The first meeting of the House of Delegates will be held on Thursday at 3:30, when chairmen of all regular committees and the chairman of the Council will present their annual reports; the second meeting will be held on Friday at 9:30 a.m.

Specialty groups will hold meetings simultaneously on Thursday forenoon.

Practically all of the available space in the exhibit hall has already been reserved. Doctors and guests will find the exhibits this year of especial interest, although there will be no elaborate displays, owing to the restriction of transportation facilities. Representatives of exhibiting firms will be in attendance, ready to explain new products and equipment.

Many aspects of medical practice and the relationship of the profession to allied professions, hospitals and agencies of government are changing so rapidly that it is becoming more and more imperative for all those who can to attend the annual meeting. Everyone owes it to his community to keep abreast of these changes. More and more the public wants to know what is happening in medicine. It is only right that it should be able to obtain accurate and up-to-date information concerning these changes from the physicians in each locality. At the annual meeting the physician is presented with the opportunity of catching up with the latest information and to fill in the gaps which may have occurred since the previous annual meeting.

In the convention number of the Journal, which will be the April issue, the complete program will be shown.

**TEMPORARY LICENSING OF RELOCATED PHYSICIANS**

All of the formalities prerequisite to putting into effect the plan in Florida for the temporary licensing of relocated physicians for the war emergency have been signed, according to a communication, dated January 15, 1944, received from the Honorable George L. Burr, Jr., Executive Director of the State Defense Council of Florida. On request, Honorable J. Tom Watson, Attorney General, has submitted the plan which was approved.

Briefly stated the procedure is as follows: The Governor by Executive Order (A) directs the State Defense Council to license during the war emergency relocated physicians in particular counties, provided it first receives:

A certificate of need (B) for such a physician from the County Medical Society, or, in the absence of a County Medical Society, a certificate to such effect from the Board of Governors of the Florida Medical Association. Such certificate must give the name of the physician, the state in which he last practiced, the fact that he

was in good standing in that state, and a statement that his educational qualifications meet our state requirements. Such certificate must be approved by the State Office of Medical Procurement and Assignment Service.

A certificate from the State Board of Medical Examiners (C) approving the procedure for the temporary licensing of relocated physicians.

A certificate from the State Board of Health (D) approving the procedure for temporary licensing of relocated physicians.

Resolution from the Board of Governors of the Florida Medical Association (E) approving the procedure.

Resolution of the State Defense Council (F) issuing the license to the physician certified to practice in a particular county only, subject to the same laws and regulations as other physicians, his license subject to revocation by operation of law or by direction of the Governor; but in no event shall the license continue in effect longer than six months after the end of World War II.

The plan is drafted under the statutory emergency powers of the State Defense Council to meet emergency needs during the war.

#### DIRECTIVE, CERTIFICATES AND RESOLUTIONS

##### **A—TO THE STATE DEFENSE COUNCIL, HONORABLE GEORGE L. BURR, EXECUTIVE SECRETARY, TALLAHASSEE, FLORIDA**

The State Defense Council of Florida upon receipt of the following:

(1) Certificate from the county medical society (or association) having jurisdiction of any county in Florida that there is a need in such county in any particular branch of the medical profession for one or more additional doctors due to an inadequate supply of doctors in that particular county; and certifying the name of the physician for temporary licensing to meet such need and that such physician meets the following requirements: (a) was in good standing in the state and area where he last practiced; (b) that he meets the educational requirements for such a physician imposed under the laws of Florida; (c) that such physician was duly qualified under the laws of the state where he last practiced medicine to practice the particular branch in which he is asked to be admitted under temporary license; provided that in the absence of a county medical society having jurisdiction over any county that the Board of Governors of the Florida Medical Association may make the said certificate. Provided, further, that any such certificate shall only become effective upon being approved by the State Office of Medical Procurement and Assignment.

(2) One formal certificate of the State Board of Medical Examiners that in cases where any such certificate referred to in (1) above is made and received by the State Defense Council, that in such county such physician or physicians should be procured and brought into said county to meet the needs therein.

(3) One formal certificate from the State Board of Health to the same effect as the certificate of the State Board of Medical Examiners.

(4) One Resolution from the Board of Governors of the Florida Medical Association approving this procedure for the issuance of temporary licenses to physicians and authorizing and giving the consent of said Board to any county medical society affiliated with the Florida Medical Association to execute the foregoing certificates referred to in number (1) above.

is hereby directed to issue a temporary practicing license to such physician to practice in the particular county for the duration of such urgent need until said license is revoked by operation of law or by order of said Defense Council under the direction of the Governor of Florida; provided, however, no such license shall continue for a period longer than six months after the cessation of the present hostilities in which the United States of America is now engaged.

You are directed to issue such license in each case as it arises upon the fulfillment of all the conditions made prerequisite thereto in this Executive Order without further direction.

WITNESS the signature of the Honorable Spessard L. Holland, Governor of Florida, and the Great Seal of the State of Florida, at Tallahassee, on this 8th day of January, A. D. 1944.

(Signed) Spessard L. Holland, Governor of the State of Florida.

##### **B—CERTIFICATE OF THE COUNTY MEDICAL SOCIETY (OR IN ABSENCE OF A COUNTY MEDICAL SOCIETY BY THE BOARD OF GOVERNORS OF THE FLORIDA MEDICAL ASSOCIATION).**

This is to certify to the State Defense Council of Florida that the ..... County Medical Society (or Association) having jurisdiction of the said County does hereby certify to the State Defense Council of Florida that there is a need in such county in the following branch of the medical profession. .... for a physician due to an inadequate supply of doctors in that particular branch or branches in said county.

That the following physician, Dr. ..... can be procured to meet such need and that said physician meets the following requirements: (a) He was in good standing in the State of ..... in the City of ..... or in the County of ..... of said state, in which he last practiced; (b) He meets the educational requirements imposed for such a physician under the laws of Florida, and (c) He was duly qualified under the laws of said state where he last practiced medicine to practice the following branch of the medical profession: .....

Adopted by the ..... County Medical Society this ..... day of ..... , A. D. 1944, at ..... , Florida.

County Medical Society

By ..... President or Secretary of said Society.

Approved this ..... day of ..... , A. D. 1944.  
State Office of Medical Procurement  
and Assignment.

By

##### **C—CERTIFICATE OF STATE BOARD OF MEDICAL EXAMINERS OF FLORIDA**

The State Board of Medical Examiners of Florida hereby certifies to the State Defense Council that in those cases where the medical association having jurisdiction of the county involved certifies to the State Defense Council the existence of the great need in that county for doctors in any branch of the medical profession because of the inadequacy of the supply of such doctors in that particular branch in such county and requests of said State Defense Council the temporary licensing of any particular person to practice the particular branch of

medicine so certified in such county, that in such cases a physician should be procured and brought into the county involved under whatever legal power and authority the said Defense Council may have for accomplishing the same; provided the medical society having jurisdiction in the county in question certifies to said State Defense Council the following: (1) that the physician desired was in good standing in the State and area where he last practiced; (2) that such physician meets the educational requirements imposed under the laws of Florida; and (3) that such physician was duly qualified under the laws of the State where he last practiced medicine to practice the particular branch in which he will be engaged when admitted in Florida.

It being the purport of this certificate that such temporary license be issued only for that period of time during which the State Defense Council will be authorized to issue the same under the emergency conditions upon which it is predicated.

The State Board of Medical Examiners will register such temporary licensee as being legally permitted to practice medicine in the State of Florida for the period embraced in such license so issued in the branch thereof for which the license applies, provided the Governor of Florida issue a direction to said State Defense Council of appropriate action therefor in advance of the issuance of such license.

The State Board of Medical Examiners further certifies that it has authorized its Secretary in each instance where such a physician has been temporarily licensed by the State Defense Council as contemplated by the foregoing procedure, and due notification of the issuance of such temporary license has been furnished said Secretary of the State Board of Medical Examiners by the State Defense Council, to certify the name of such physician so licensed to the State Board of Health, Bureau of Narcotics as being legally permitted under such temporary license to practice medicine in the State of Florida.

WITNESS the official signature and seal of said State Board of Medical Examiners, at Tampa, Florida, this 11th day of January, A. D. 1944.

STATE BOARD OF MEDICAL EXAMINERS  
(Signed) W. M. Rowlett, M. D.  
Its Secretary.

**D—CERTIFICATE OF STATE BOARD OF HEALTH OF FLORIDA.**

The State Board of Health of Florida hereby certifies to the State Defense Council that in those cases where the medical association having jurisdiction of the county involved certifies to the State Defense Council the existence of the great need in that county for doctors in any branch of the medical profession because of the inadequacy of the supply of such doctors in that particular branch in such county and requests of said State Defense Council the temporary licensing of any particular person to practice the particular branch of medicine so certified in such county, that in such cases a physician should be procured and brought into the county involved under whatever legal power and authority the said Defense Council may have for accomplishing the same; provided the medical society having jurisdiction in the county in question certifies to said State Defense Council the following: (1) that the physician desired was in good standing in the State and area where he last practiced; (2) that such physician meets the educational requirements imposed under the laws of Florida, and (3) that such physician was duly qualified under the laws of the State where he last practiced medicine to practice the particular branch in which he will be engaged when admitted in Florida.

It being the purport of this certificate that such temporary license be issued only for that period of time during which the State Defense Council will be authorized to issue the same under the emergency conditions upon which it is predicated.

The State Board of Health will register such temporary physician as legally entitled to practice medicine in the State of Florida for the period embraced in such licenses so issued, provided the Governor of Florida issue a direction to said State Defense Council of appropriate action therefor in advance of the issuance of such license.

WITNESS the official signature of the State Board of Health by its duly authorized registrar, and its official and corporate seal, at Jacksonville, Florida, this 10th day of January, A. D. 1944.

STATE BOARD OF HEALTH  
(Signed) Henry Hanson, M. D.  
State Health Officer.

**E—RESOLUTION OF THE BOARD OF GOVERNORS OF THE FLORIDA MEDICAL ASSOCIATION.**

BE IT RESOLVED BY THE BOARD OF GOVERNORS OF THE FLORIDA MEDICAL ASSOCIATION that it hereby approves the procedure for the temporary licensing of physicians by the State Defense Council of Florida as such procedure is evidenced by a proposed Executive Order of the Governor, which Order reads as follows, to-wit:

TO THE STATE DEFENSE COUNCIL, HONORABLE GEORGE L. BURR,  
EXECUTIVE SECRETARY, TALLAHASSEE, FLORIDA.

The State Defense Council of Florida upon receipt of the following:

(1) Certificate from the county medical society (or association) having jurisdiction of any county in Florida that there is a need in such county in any particular branch of the medical profession for one or more additional doctors due to an inadequate supply of doctors in that particular county; and certifying the name of the physician for temporary licensing to meet such need and that such physician meets the following requirements: (a) was in good standing in the state and area where he last practiced; (b) that he meets the educational requirements for such a physician imposed under the laws of Florida, (c) that such physician was duly qualified under the laws of the state where he last practiced medicine to practice the particular branch in which he is asked to be admitted under temporary license; provided that in the absence of a county medical society having jurisdiction over any county that the Board of Governors of the Florida Medical Association may make the said certificate. Provided, further, that any such certificate shall only become effective upon being approved by the State Office of Medical Procurement and Assignment.

(2) One formal certificate of the State Board of Medical Examiners that in cases where any such certificate referred to in (1) above is made and received by the State Defense Council, that in such county such physician or physicians should be procured and brought into said county to meet the needs therin.

(3) One formal certificate from the State Board of Health to the same effect as the certificate of the State Board of Medical Examiners.

(4) One Resolution from the Board of Governors of the Florida Medical Association approving this procedure for the issuance of temporary licenses to physicians and authorizing and giving the consent of said Board to any county medical society affiliated with the Florida Medical Association to execute the foregoing certificates referred to in number (1) above.

is hereby directed to issue a temporary practicing license to such physician to practice in the particular county for the duration of such urgent need until said license is revoked by operation of law or by order of said Defense Council under the direction of the Governor of Florida; provided, however, no such license shall continue for a period longer than six months after the cessation of the present hostilities in which the United States of America is now engaged.

You are directed to issue such license in each case as it arises upon the fulfillment of all the conditions made prerequisite thereto in this Executive Order without further direction.

WITNESS the signature of the Honorable Spessard L. Holland, Governor of Florida, and the Great Seal of the State of Florida, at Tallahassee, on this.....day of....., A. D., 1944.

Spessard L. Holland, Governor  
of the State of Florida.

Adopted this 6th day of January, A. D. 1944.

BOARD OF GOVERNORS,  
FLORIDA MEDICAL ASSOCIATION.  
(Signed) R. D. Ferguson, M. D.  
Chairman.

**F—RESOLUTION OF THE STATE DEFENSE COUNCIL AUTHORIZING ISSUANCE OF TEMPORARY MEDICAL LICENSE TO DR. ....  
TO PRACTICE IN THE COUNTY OF.....**

WHEREAS, pursuant to an Executive Order of the Honorable Spessard L. Holland, Governor of the State of Florida, under date of January 8, A. D. 1944 (which Executive Order is spread upon the Minutes of the Defense Council of its meeting on the ..... day of ..... A. D. 1944), the State Defense Council has been authorized to issue temporary licenses to physicians upon receiving certain certificates and resolutions; and

WHEREAS, the Defense Council pursuant to the provisions of said Executive Order has received the following: (1) Certificate from the ..... Medical Society (or Association) (or from the Board of Governors of the Florida Medical Association) certifying the need for the temporary licensing of Dr. .... to practice in said county, and certifying to his qualifications, which certificate has been approved by the State Office of Medical Procurement and Assignment Service; (2) Certificate of the State Board of Medical Examiners; (3) Certificate of State Board of Health, and (4) Resolution of the Board of Governors of the Florida Medical Association, all of which documents conform to the requirements of said Executive Order.

THE PREMISES CONSIDERED, BE AND IT IS HEREBY RESOLVED BY THE STATE DEFENSE COUNCIL OF FLORIDA, that a temporary physician's license in the following form is hereby directed to be issued to said ..... to-wit:

STATE DEFENSE COUNCIL OF FLORIDA, TALLAHASSEE, FLORIDA, TEMPORARY MEDICAL LICENSE FOR THE PRACTICE OF MEDICINE IN THE COUNTY OF ....., FLORIDA

TEMPORARY LICENSE NO. ....

This is to certify that Doctor ..... is granted a temporary license to practice medicine in the medical branch of ..... in the County of ..... , Florida, all prerequisites for such temporary license having been complied with as required under the Executive Order of the Governor of Florida dated the 8th day of January, A. D. 1944, for the temporary licensing of physicians.

The physicians temporarily licensed hereby shall be subject to all laws regulating and governing regularly licensed physicians of this state and this license is to continue in effect until revoked by operation of law or by order of the Defense Council upon direction of the Governor of Florida; provided, however, this license shall in no event continue in effect for a period longer than six months after the cessation of the present hostilities in which the United States of America is now engaged.

Dated this ..... day of ..... , at ..... , Florida, and issued under authority of said State Defense Council.

Executive Director, State Defense Council  
of Florida.

Countersigned:

Leigh F. Robinson, M. D., Chairman  
Division of Health and Housing,  
State Defense Council of Florida.

MEDICAL LICENSES GRANTED

Licenses to practice medicine in Florida must henceforth be registered within sixty days of the date shown on the license, in accordance with an amendment to the Florida statutes which became effective June 11, 1943. The original law required that every license to practice medicine be registered in the office of the clerk of the circuit court of the county in which the licensee resides or in which his practice is intended to be carried on, but no time limit was specified. In some instances licenses were recorded as late as twenty years after the date of issuance. It is expected that the new law will help prevent the recording of fraudulent licenses.

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that fifty-five applicants were successful in passing the recent examination of the Board held in Jacksonville on November 22-23, 1943. Their names, addresses, college and year of graduation are as follows:

Albee, Fred H., Jr., Venice (Duke, 1943)  
Barton, Wm. K., Pass-a-Grille (Washington, 1943)  
Bixler, Thomas J., Live Oak (Emory, 1943)  
Burns, LaVerne T., Detroit (Temple, 1943)  
Carr, Orlon V., Jr., Miami (Vanderbilt, 1943)  
Corbett, Sybill, Jasper (Md., 1942)  
Cravet, Geo. M., Jacksonville (Tenn., 1943)  
Dickey, James W., Jr., Ft. Lauderdale (Duke, 1943)  
Donegan, Charles K., Largo (Duke, 1943)  
Eck, Daniel B., Orlando (Creighton, 1938)  
Edwards, Joshua L., Lake City (Tulane, 1943)  
Floren, Roger C., Orlando (Med. Evang., 1939)  
Frazier, John W., Jr., Tampa (Jefferson, 1924)  
Gatling, Willard R., Jacksonville (Tenn., 1943)  
Griffith, John W., Jr., Miami (Vanderbilt, 1943)  
Harris, Charles M., Jr., Belle Glade (Emory, 1940)  
Hendricks, Anne L., Ft. Lauderdale (Cincinnati, 1943)  
Hilsenbeck, John R., Miami (Vanderbilt, 1941)  
House, Curtis R., Miami (Tulane, 1943)  
Ingram, J. M., Jr., Tampa (Duke, 1943)  
Jewett, Jim S., Carmel, Ind. (Indiana, 1942)  
Jones, Oliver L., Hopewell, Va. (Va., 1927)  
Keeffe, Jack, III, Miami (Vanderbilt, 1943)  
Kernish, Alexander I., Jacksonville (Jefferson, 1935)  
Kinzie, Joseph L., Salem, Va. (Va., 1933)  
Kleckner, O. Frank, Dunedin (Duke, 1932)  
Kleinman, Samuel B., Alexandria, La. (Rush, 1938)  
Kovnat, Maurice, Staten Island, N. Y. (Bellevue, 1921)  
Ludwig, Edward W., Miami (Ohio, 1943)  
MacVeany, Arthur P., Miami (Columbia, 1927)  
Matthews, John B., St. Petersburg (Rush, 1903)  
Moss, Abner J., Miami (Buffalo, 1935)  
Palamar, Michael, Jacksonville (Georgetown, 1942)  
Phillips, Herman A., Brooklyn, N. Y. (N. Y., 1928)  
Pride, Atwell B., Winston-Salem, N. C. (Meharry, 1943)  
Ramage, Raymond C., Jacksonville (Duke, 1943)  
Rhodes, Bernard L., Jr., Live Oak (Duke, 1943)  
Roach, Fleming D., Ft. Lauderdale (Ga., 1942)  
Roth, Emanuel, Winter Park (Va., 1927)  
Schofman, Manuel A., Miami (Louisville, 1943)  
Shapley, Benjamin S., Orlando (Ill., 1928)  
Smedley, John T., Jacksonville (Tenn., 1943)  
Standard, Ruth E., Washington, D.C. (Med. Evang., 1941)  
Swihart, Glenn L., Lakeland (Ind., 1940)  
Swing, Frederick P., Cincinnati (Cincinnati, 1934)

Taylor, G. Dekle, Jacksonville (Mich., 1943)  
Tew, Alton H., Miami (Emory, 1942)  
Thomas, Merrick D., Jr., Miami (Tulane, 1943)  
Vaisberg, Maurice, Miami Beach (L. I., 1930)  
Vandeveer, Rudolph E., Rome, N. Y. (Yale, 1932)  
Waldrep, Jack M., Leesburg (Emory, 1943)  
Watson, John E., Jacksonville (Ark., 1943)  
Watt, James H., Great Neck, N. Y. (Buffalo, 1920)  
Weinstein, Louis, Breaux Bridge, La. (Tulane, 1932)  
Withers, Robert W., Tampa (Duke, 1943)

## BIRTHS AND DEATHS

### BIRTHS

Dr. and Mrs. E. Thomas Kinsey of Madison announce the birth of a daughter, Victoria Amanda, on November 10.

Dr. and Mrs. Harry S. Howell of Lake City announce the birth of a daughter, Rocena Edwards, on January 21.

### DEATHS

Dr. James M. Hoffman of Pensacola died on January 19.

## STATE NEWS ITEMS

Dr. Eugene G. Peek of Ocala spent some time at the Association's headquarters office in Jacksonville on February 10. President Peek feels that plans for a successful convention in St. Petersburg are shaping up nicely.

Dr. Herbert W. Virgin, Jr., of Miami has resumed practice after having been inactive for a period of two years due to illness. His friends will be pleased to learn that he is able to take up his regular duties again.

Dr. Theodore G. Croft of Jacksonville was principal speaker at the launching of the St. Johns River Shipbuilding Company's twenty-seventh Liberty ship, the S.S. Royal S. Copeland, on January 11.

DON'T MISS THE

ANNUAL CONVENTION

St. Petersburg

April 13 and 14, 1944

Headquarters: Princess Martha Hotel

## JAMES MORTIMER HOFFMAN

Dr. James M. Hoffman, 43, prominent Pensacola surgeon, died unexpectedly at his home Wednesday, January 19, 1944. He had practiced in Pensacola for the past eighteen years, retiring last June following a heart attack from which he never had fully recovered. He specialized in obstetrics and gynecology.

Dr. Hoffman was born in New Orleans, where he attended parochial schools. Later he attended Loyola and Tulane universities, where he starred in competitive sports as a basketball player. Following his internship he served on the staffs of Charity Hospital and Hotel Dieu, a private institution, both located in New Orleans.

Coming to Pensacola eighteen years ago, Dr. Hoffman took over the x-ray department of the Pensacola Hospital; later he became associated with Dr. Herbert L. Bryans and then with Dr. Warren E. Anderson. During the past few years he maintained his own offices on East DeSoto Street near the Pensacola Hospital.

Dr. Hoffman was a member of the Cancer Control Committee of the Florida Medical Association and the Radiological Society of North America. He was past president and secretary of the Escambia County Medical Society, a past president of the Pensacola Hospital staff, and president of the staff of the Maternity Home, on which he took an active part up to the time of his illness last year. He was a member of the State Board of Censors, Knights of Columbus; St. Vincent DePaul Society; Elks; Y.M.C.A., of which he was a local official; Southeastern Surgical Congress; American College of Surgeons, and the Southern Atlantic Association of Obstetricians and Gynecologists.

He is survived by his wife, Edith; four sons, James M., Jr., of the U. S. Army Air Corps, Charles L., of New Orleans, Milton and Robert of Pensacola; one daughter, Edith, and his mother, Mrs. Virginia Hoffman of New Orleans. Also surviving are three brothers, Dan and August of New Orleans, and John of Lafayette, La.; two sisters, Mrs. R. J. Foucher of New Orleans and Sister Mary Promptsuccor of the House of Good Shepherd, St. Louis.

### FRANK TALMADGE BARKER

Dr. Frank T. Barker of Tampa died suddenly of a heart attack on January 5 at his office in the Maas building.

Born in Tampa, Nov. 12, 1896, he was a member of one of Florida's oldest pioneer families. His great-grandfather, William Barker, homesteaded in Florida about 100 years ago and took part in the early Seminole Indian wars. Dr. Barker's mother, Julia Josephine Jackson Barker, who survives him, was also a pioneer and often told him of the wild life of early days in the state.

Dr. Barker attended public schools in Tampa and was graduated from Hillsborough high school in 1914. He took his pre-medical training at Washington and Lee university on a scholarship which he won in high school. Later he went to the University of Maryland and to the College of Physicians and Surgeons at Baltimore.

After his graduation in medicine he accepted an appointment as resident surgeon of the City Hospital of Baltimore where he served for a year. He also interned at Maryland General Hospital, Mercy Hospital and University Hospital and did special work at the Johns Hopkins Hospital.

During the last war he was a lieutenant in the naval medical corps and saw service in Egypt, Arabia, China and the Philippines.

Dr. Barker began his practice in Tampa in 1924 and became a member of the staffs of the Tampa and St. Joseph's hospitals.

Dr. Barker was an active member of the Hillsborough County Medical society, the Florida Medical Association, the Southern Medical Association and the American Medical Association. In addition he was a member of the Florida Association of Industrial Surgeons, the American Congress of Physical Therapy, the Randolph Winslow Surgical Society and other scientific organizations. He was also a member of several medical and academic fraternities, including Kappa Alpha, Chi Zeta Chi, Alpha Omega Kappa and Phi Rho Sigma.

He was a member of the U. S. S. Tampa post, American Legion; Tampa lodge, No. 708, of Elks; John Darling lodge, of Masons; Scottish Rite Masons; Royal Arch Masons; the Egypt Temple Shrine, and St. Andrew's Episcopal church.

Dr. Barker was active in politics as chairman

of the Downtown Democratic club, which he organized in 1931.

In 1934 he was married to Miss Frances Pineda of Tampa.

He is survived by his widow and mother.

### WILLIAM JOSEPH HOLTON

Dr. William J. Holton of Plant City died on January 7, 1944 at the Bay Pines Hospital, at the age of 60.

A graduate of the Georgia Medical School and the Chicago School of Eye, Ear, Nose and Throat, Dr. Holton practiced in Olympia, Ga., and White Springs, Fla., before coming to Plant City in 1914. He served in the United States Army for three years in the Philippines just after the insurrection.

Dr. Holton was a member of the Hillsborough County Medical Society, the Florida Medical Association and the American Medical Association.

Survivors are his widow, Mrs. Martha F. Holton; two sons, William J. of Atlanta, and John H. of the U. S. Navy; and one grandson, Charles W. Holton of Atlanta.

### COMPONENT COUNTY SOCIETIES

#### BAY

At the annual meeting of the Bay County Medical Society, Dr. Don S. Fraser was elected president and Dr. J. O. Barfield was chosen secretary-treasurer.

This society is among the first to join the honor roll of 100% paid societies, forwarding the dues for all of its members to the Association treasurer during the month of January.

#### COLUMBIA

The following officers were elected in December by the Columbia County Medical Society: president, Dr. H. S. Howell; vice president, Dr. W. S. Nichols, and secretary-treasurer, Dr. Thomas H. Bates, all of Lake City.

The members of this society have all paid their dues for 1944, placing the organization on the Association's honor roll of 100% paid societies.

## DADE

The regular monthly meeting of the Dade County Medical Society was held Tuesday evening, January 4, in the library of the Jackson Memorial Hospital; Dr. Wiley M. Sams, president, presided. Following a business session, the meeting was turned over to Dr. Perry Melvin, program chairman. Dr. Philipp Rezek and his associates at the hospital conducted a clinical pathologic conference. The Reverend Bart of Miami, representing the American Soviet Friendship Society, then spoke briefly concerning the objectives of that organization.

## DeSOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES

During the month of January the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society forwarded to the Association treasurer its roster and dues for 100% of its members. Heading this society are Drs. M. C. Kayton, president, and Dr. C. H. Kirkpatrick, secretary-treasurer.

## DUVAL

Dr. Robert B. McIver was principal speaker at the meeting of the Duval County Medical Society held at St. Luke's Hospital, Jacksonville, on the evening of February 2. He illustrated his subject, "Disposition of Obstructive Aberrant Renal Vessels," with colored motion pictures.

## LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON

At the annual meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, held at the Floridan Hotel, Tallahassee, on the evening of January 20, the following officers were elected: president, Dr. J. L. Williams, Tallahassee; vice president, Dr. A. S. Turk, Chattahoochee; secretary-treasurer, Dr. L. I. Dozier, Tallahassee.

## MANATEE

The new officers of the Manatee County Medical Society are: president, Dr. S. G. Hollingsworth, Bradenton; vice president, Dr. Blake Lancaster, Manatee; and secretary-treasurer, Dr. Lowrie W. Blake of Bradenton.

## NASSAU

At a meeting of the Nassau County Medical Society held at the Nassau County Hospital, Fernandina, on January 11, the following officers were elected to serve for 1944: president, Dr. W. A. Brewster of Callahan; vice president, Dr. L. L. Bunker, Fernandina; and secretary-treasurer, Dr. George A. Dame, Fernandina. Dr. Dame was also chosen delegate to the annual meeting of the State Association.

## PALM BEACH

An exchange of medical notes took place between members of the Palm Beach County Medical Society and the officers of the Camp Murphy Medical Staff at a meeting held at the station hospital in January. Maj. J. M. Harsha, post medical officer, presided. Col. James Green, post commandant, was the guest speaker.

Following a dinner in the hospital mess hall, the gathering made a tour of inspection of the facilities, including wards, recreation room, surgery, medical supply, the E.E.N.T. clinic, pharmacy, psychiatric ward and the dental clinic. Interesting cases of a medical nature were discussed.

## PASCO-HERNANDO-CITRUS

A meeting of this society was held Thursday evening, January 13, in Brooksville at the home of Dr. S. C. Harvard. Interesting clinical cases were reported by Drs. C. L. Carter, G. R. Creekmore, W. W. Jones and W. H. Walters. Preceding the meeting a grilled steak dinner was served on the lawn at the home of Dr. and Mrs. Harvard. A hearty vote of appreciation was extended to the hosts. In addition to those who participated in the program, Drs. A. C. Coogler, S. C. Harvard, P. J. Hudson and W. B. Moon were present.

Dr. P. J. Hudson extended an invitation for the society to meet with him Thursday, February 10, at Crystal River.

## PINELLAS

Dr. J. B. Quicksall, committee chairman, conducted a symposium on "Public Health and Medical Economics" at a dinner meeting of the Pinellas County Medical Society held on the evening of January 7.

On January 21, members of this society met at the home of Dr. R. E. Dicks for a round table discussion. Dr. Dicks acted as moderator.

## ST. JOHNS COUNTY MEDICAL SOCIETY

This society has forwarded to the State Association a check covering 100% of 1944 dues for its members. Officers of this society for the current year are: president, Dr. G. W. Potter; vice president, Dr. A. C. Walkup; secretary, Dr. Charles C. Grace; and treasurer, Dr. R. D. Harris.

## SARASOTA

At a meeting of the Sarasota County Medical Society held at the Sarasota Hospital, January 8, the following officers were elected: president, Dr. O. H. Cribbins; vice president, Dr. T. W. Taylor; and secretary-treasurer, Dr. J. E. Harris. The members of this society have all paid their dues for 1944, placing the organization on the Association's honor roll of 100% paid societies.

## SEMINOLE

The regular meeting of this society was held at the Fernald-Laughton Memorial Hospital, Tuesday, January 11, at 8 p.m. By vote of the members present, a motion picture produced by the Singer Sewing Machine Company, demonstrating a surgical instrument, will be shown at the next meeting. Members present were Drs. Samuel Puleston, J. A. Smith, Leland H. Dame, J. N. Robson, W. T. Langley, Wade H. Garner and G. S. Selman.

At the December meeting of the society, Dr. Samuel Puleston entertained the members at dinner. Through an oversight, this did not appear in the writeup in the February issue of the Journal.

## WALTON-OKALOOSA

Dr. E. L. Huggins of DeFuniak Springs was elected president of this society at its annual meeting. Other officers are Dr. R. B. Spires of Defuniak Springs, vice president, and Dr. A. G. Williams of Lakewood, secretary-treasurer. This society is on the Association's honor roll, having paid 100% of its dues for 1944.

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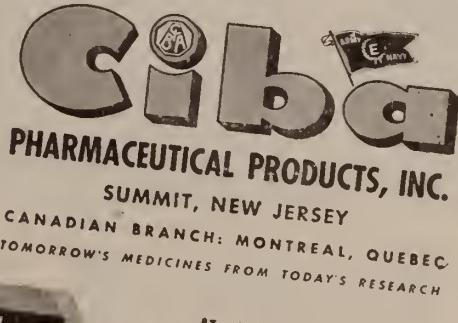
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#### GLASSES RETRIEVED FROM CONCRETE MIXER

Dr. J. B. McMurray, Washington, Pa., recently transmitted to White-Haines Optical Co., Columbus, Ohio, a letter from Mrs. Charles L. Daily, of Steubenville, Ohio, concerning the adventures of a pair of glasses of Bausch & Lomb make.

Mrs. Daily related that her husband dropped his glasses into thirty feet of water at Brown's Island one Sunday. They were found in a batch of concrete the following Wednesday at Mingo Junction. It transpired that they had been dug up by a dredge and dumped into a barge. The barge had been towed downstream five miles to the South Street landing in Steubenville. There the load of sand and gravel was transferred to a bin on shore and ultimately portions of it were fed into a concrete mixer which mixed a batch of cement enroute to Mingo Junction.

The contractor on the road at Mingo Junction, a Mr. Bates, spied a foreign object in the cement as it was being laid. He fished out a pair of glasses unharmed except for a couple of small scratches on the lenses. They turned out to be Mr. Daily's and are now back in service.

Mrs. Daily suggests this is one for Ripley.

#### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

PATHIOLOGY AND THERAPY OF RHEUMATIC FEVER. By Leopold Lichtwitz, M. D. In this keenly awaited volume, Dr. Lichtwitz, by accolade of his colleagues "our foremost authority on the pathology of function," sums up the scientific logic of his concept of the immemorially baffling processes of rheumatic pathology. The study carries through an inclusive classification and analysis of the various types of rheumatic and arthritic affection. The pathology by which these shape the ground for fatal functional and structural major involvements is set forth both in the whole perspective and with detailed clinical precision. Cloth. Price, \$4.75. Pp. 225, with 69 illustrations. New York: Grune & Stratton, Inc., 1944.

ESSENTIALS OF DERMATOLOGY. (Second Edition). By Norman Tobias, M. D., Senior Instructor in Dermatology, St. Louis University, St. Louis. This brief treatise on diseases of the skin was conceived with the idea of placing a handy volume at the disposal of general practitioners and medical students who often have neither time nor inclination to refer to the larger standard dermatologic textbooks. The author has attempted to present the growing subject of dermatology completely and concisely without the sacrifice of detail. Histologic descriptions and theoretic considerations have been reduced to a minimum to fit in with the scope of the book. During the past ten years so many advances have been made in allied fields that dermatology has benefited considerably. Wherever possible these newer facts have been incorporated in the text so that the subjects are up-to-date. Cloth. Price, \$4.75. Pp. 497, with illustrations. Philadelphia: J. B. Lippincott Company, 1944.

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OBSTETRICS—Two Weeks Intensive Course starting April 17 and June 26.

ANESTHESIA—Two Weeks Course Regional and Intravenous Anesthesia.

GASTROSCOPY—Personal Course starting April 3, June 19, and October 16.

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 Mrs. W. J. BARGE, Archives.....*DeLand*  
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 Mrs. P. J. MANSON, Organization.....*Miami*  
 Mrs. C. E. ROYCE, Bulletin.....*Jacksonville*

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**DUVAL COUNTY AUXILIARY**

An outstanding meeting of the Woman's Auxiliary to the Duval County Medical Society was held on Thursday afternoon, January 13, in the home of Mrs. Raymond H. King. Mrs. C. W. Johnston served as co-hostess.

Mrs. S. R. Norris, vice-president and program chairman, introduced the guest speaker, Mr. Harold S. Cohn, editor of the Jacksonville Journal, who gave a most interesting address on the subject, "Civilizations Disappear." Mr. Cohn stated that our own civilization is in danger of being lost, as ancient ones were, unless its citizens begin to realize their responsibilities, one to another. Mrs. J. W. Hayes, president, expressed the gratitude of the Auxiliary to Mr. Cohn for his appearance which was well received and enjoyed by every member.

During the business session, reports were heard from officers and committee chairmen. Mrs. Charles Henley, defense chairman, reported that ten Christmas boxes had been sent overseas and that records, detective stories, Christmas decorations and favors were supplied to an Army Base at Atlantic Beach. The Auxiliary voted additional funds to the committee with which to continue its work.

Mrs. F. W. Krueger read a letter from Opportunity House thanking the Auxiliary for the gift of toys in October.

Mrs. Hayes introduced as a special guest of the Auxiliary, Dr. Margaret Carraway, founder

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of the Mississippi Coast Auxiliary, which celebrated its twentieth anniversary this year. Dr. Carraway graciously extended greetings from that organization.

Mrs. Victor Hughes, social chairman, announced that the March meeting would be held in the home of Mrs. Albert Wilkinson. She stated that Mrs. Norris had arranged a most interesting program at which time Commander M. J. Capron of the United States Naval Hospital in Jacksonville would speak on the drug, "Penicillin."

During the social hour, Mrs. King and Mrs. Johnston were assisted in serving by Mrs. Hughes and Mrs. James L. Borland.

#### NATIONAL BULLETIN

The following message has just reached us from Mrs. Luella H. Goodson, National Chairman of Press and Publicity: "Half of our Auxiliary year has passed and we are now beginning the last half. As a special project, won't you try to help increase the circulation of the National Bulletin by sending in your subscription today?"

The price of the National Bulletin is \$1.00 a year, and is indispensable to our growth and progress. It is published quarterly and contains information that every auxiliary member should know. To be active, we must become well informed. You will get larger returns for the dollar you invest in the Bulletin than any other publication on the market. Won't you send your subscription to Mrs. William H. Goodson, 37 Moss St., Liberty, Mo. without delay?

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#### SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Eugene G. Peek, Ocala.....	Shaler Richardson, Jacksonville.....	St. Petersburg, Apr. 13-14, 1944
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville....	"         "         "         "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland.....	"         "         "         "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach....	"         "         "         "	Miami, Postponed
American Medical Association.....	James E. Paullin, Atlanta, Ga.....	Olin West, Chicago.....	Chicago, June 12-16, 1944
Southern Medical Association .....	W. T. Wootton, Hot Spgs., Ark.....	Mr. C. P. Loranz, Birmingham.....	November, 1944
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	Montgomery, Apr. 18-20, 1944
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	Savannah, May 9-12, 1944
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg....	Kenneth Phillips, Miami.....	St. Petersburg, April 13, 1944
Basic Science Exam. Board .....	M. W. Emmel, D.V.M., Gainesville	J. F. Conn, Ph.D., DeLand.....	Gainesville, June 8, 1944
Dental Society, State.....	E. C. Lunsford, D.D.S., Miami .....	H. L. Cartee, D.D.S., Miami.....	St. Petersburg, April 13, 1944
Derm. and Syph., Soc. of.....	Wiley M. Sams, Miami.....	Lauren M. Sompayrac, Jacksonville	Postponed
East Coast Medical Association....	T. C. Kenaston, Cocoa.....	I. M. Hay, Melbourne.....	
Hospital Association.....	Mr. W. E. Arnold, Jacksonville .....	Miss Katharine Moyer, Lake Wales .....	St. Petersburg, April 13, 1944
Industrial Surgeons, Assn. of.....	Frank D. Gray, Orlando.....	A. M. Bidwell, Tampa .....	Jacksonville, June 26, 27, 1944
Medical Examining Board .....	George S. McClellan, Pompano .....	W. M. Rowlett, Tampa .....	
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville.....	Chairman	
Nurses Association, State.....	Miss Florence Jones, Jacksonville	Miss Madalee Hazel, Limona .....	St. Petersburg, April 13, 1944
Ophthal. & Otol., Soc. of.....	Shaler Richardson, Jacksonville....	C. E. Dunaway, Miami.....	St. Petersburg, April 13, 1944
Pathological Society.....	L. Y. Dyrenforth, Jacksonville....	Iva C. Youmans, Miami.....	To Be Announced
Pediatric Society.....	Ludo von Meysenbug, Daytona B.	Robert Blessing, Ft. Lauderdale.....	Miami, To Be Announced
Pharmaceutical Association, State.....	Mr. H. B. Douglas, Bonifay.....	Mr. R. Q. Richards, Ft. Myers .....	
Public Health Association .....	Leland H. Dame, Sanford .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	John N. Moore, Ocala.....	Walter A. Weed, Orlando .....	St. Petersburg, April 13, 1944
Railway Surgeons' Association....	Frank D. Gray, Orlando.....	W. C. Page, Cocoa .....	Postponed for Duration
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales .....	Mrs. May Pynchon, Jacksonville .....	
Chattohoochee Valley Med. Assn.....	Herbert E. White, St. Augustine .....	Robert B. McIver, Jacksonville .....	Postponed
Gulf Coast Clinical Society.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	Postponed
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola .....	Kenneth Phillips, Miami .....	
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta .....	
Suwannee River Medical Society.....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City .....	Postponed

**COMPONENT SOCIETIES BY MEDICAL DISTRICTS**

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Don S. Fraser, M.D. 456 Grace Ave. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		14	100%	A-1-45 C. D. Whitaker, M.D. Marianna
Escambia *Santa Rosa	J. K. Turberville, M.D. Century	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	47	16	
Franklin-Gulf		J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	5	1	
Jackson *Calhoun	R. N. Joyner, M.D. Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	1	
Walton-Okaloocha	E. L. Huggins, M.D. DeFuniak Springs	A. G. Williams, M.D. Lakewood	3rd Thursday 8:00 P.M.	6	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	1	
Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	John L. Williams, M.D. Tallahassee	L. L. Dozier, M.D. Midyette-Moor Bldg. Tallahassee	Quarterly 8:00 P.M.	40	11	
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		7	3	
Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	G. H. Warren, M.D. Perry	Last Friday 8:00 P.M.	4	0	
Alachua *Bradford, Gilchrist, Union	Geo. C. Tillman, M.D. 505 W. University Gainesville	Chester F. Ahmann, M.D. 1043 W. Masonic Gainesville	2nd Wednesday 7:30 P.M.	26	8	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
Duval *Clay	J. G. Lyerly, M.D. 514 Greenleaf Bldg. Jacksonville 2	O. E. Harrell, M.D. 712 Laura St. Jacksonville 2	1st Tuesday 8:15 P.M.	195	158	
Marion *Levy	Robbins Nettles, M.D. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	26	18	
Nassau	W. A. Brewster, M.D. Callahan	Geo. A. Dame, M.D. Fernandina	2nd Wednesday 8:00 P.M.	8	7	
Putnam	J. Worth Brantley, M.D. Grandin	C. M. Knight, M.D. Palatka	2nd Tuesday Even Months 7:00 P.M.	9	2	
St. Johns	G. Walter Potter, M.D. East Coast Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	G. E. Christie, M.D. Box 151 Titusville	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	3	
Lake *Sumter	H. S. Cherry, M.D. Center Hill	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	16	
Orange *Osceola	Duncan McEwan, M.D. 106 E. Central Ave. Orlando	Albert C. Kirk, M.D. 823 E. Colonial Dr. Orlando	3rd Wednesday 8:00 P.M.	92	76	
Seminole	Samuel Puleston, M.D. Brumley-Puleston Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	13	5	
Volusia *Flagler	T. H. Dillard, M.D. DeLand	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	43	17	
Hillsborough	R. S. Torbett, M.D. 814 First Nat. Bk. Bldg. Tampa 2	Charles M. Gray, M.D. 306 Citizens Bldg. Tampa 2	1st Tuesday 8:00 P.M.	104	56	C-5-44 Leland F. Carlton, M.D. Tampa
Manatee	S. G. Hollingsworth, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	14	12	
Pasco-Hernando- Citrus	S. C. Harvard, M.D. Brooksville	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	11	100%	
Pinellas	J. A. Hardenbergh, M.D. 404 Power & Light Bldg. St. Petersburg 5	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg 4	1st and 3rd Fridays 6:30 P.M.	108	105	
Sarasota	O. H. Cribbins, M.D. 138 N. Link Sarasota	J. E. Harris, M.D. 224 Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	18	100%	
DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	100%	
Lee *Collier, Hendry	M. F. Johnson, M.D. Box 1266 Fort Myers	W. A. Harrison, M.D. 1029 First St. Fort Myers	3rd Tuesday 7:30 P.M.	17	100%	
Polk	W. F. Peacock, M.D. Barnett Embry Bldg. Bartow	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	62	15	
Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	E. W. Stephens, M.D. 910 Harvey Bldg. W. Palm Beach	4th Monday 8:00 P.M.	64	18	D-7-45 William Y. Sayad, M.D. West Palm Beach
St. Lucie- Okeechobee-Indian River-Martin	Francis A. Gowdy, M.D. Box 745 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	6	
Broward	J. A. Johnston, M.D. 22½ S. Andrews Ave. Ft. Lauderdale	O. C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	2nd Tuesday 8:00 P.M.	41	39	
Dade	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami, 32	J. J. Nugent, M.D. 701 Huntington Bldg. Miami, 32	1st Tuesday 8:30 P.M.	351	267	
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P.M.	6	3	

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# NUTRITIONAL ANEMIA IN INFANTS

## REASONS FOR EARLY FEEDING OF PABLUM (OR PABENA)

1. The infant's initial store of iron is rapidly depleted during the first months of life. (Mackay,<sup>1</sup> Elvehjem<sup>2</sup>). About 30% of the iron freed from the hemoglobin during the first two months is lost, and while hemoglobin destruction takes place, all infants are in negative iron balance. (Jeans,<sup>3</sup> and Usher, et al.<sup>4</sup>).
2. During the early months of life the infant obtains very little iron from milk — 1.44 mg. per day from the average bottle formula of 20 ounces or possibly 1.7 mg. per day from 28 ounces of breast milk. (Holt,<sup>5</sup> Jeans<sup>3</sup>). The incidence of nutritional anemia has been found to be high among infants confined largely to a diet of cow's milk. (Davidson, et al.<sup>6</sup> Usher, et al.,<sup>4</sup> Mackay<sup>1</sup>).

For these reasons and also because of the low hemoglobin values so frequent among pregnant and nursing mothers (Strauss,<sup>7</sup> and Gottlieb and Streat<sup>8</sup>), the pediatric trend is constantly toward the addition of iron-containing foods at an early age, both to normal infants and those with pylorospasm. (Neff,<sup>9</sup> Blatt,<sup>10</sup> Brennemann,<sup>11</sup> Monypenny<sup>12</sup>).

## THE CHOICE OF THE IRON-CONTAINING FOOD

1. Many foods high in iron actually add very little to the diet because much of the mineral is lost in cooking or because the amount fed is necessarily small or because the food has a high percentage of water. Strained spinach, for instance, contains only 1 to 1.4 mg. of iron per 100 Gm. (Bridges<sup>13</sup>).
2. To be effective, food iron should be soluble. Some foods fairly high in total iron are low in soluble iron. Thus egg yolk and liver have less soluble iron than does farina, which is very low in total iron. (Summerfeldt<sup>14</sup>). Oxalate-containing leafy vegetables are low in soluble iron and appear not to be well utilized as a source of iron by infants. (Kohler, et al.,<sup>15</sup> and Stearns<sup>16</sup>).
3. Pablum (and Pabena) are high both in total iron (30 mg. per 100 Gm.) and soluble iron (7.8 mg. per 100 Gm.) and can be fed in significant amounts at an early age, without digestive upsets. (Blatt,<sup>10</sup> Monypenny<sup>12</sup>). Clinical studies of sick and well babies have shown Pablum to be of value in raising hemoglobin values (Crimm, et al.,<sup>17</sup> Summerfeldt and Ross<sup>18</sup>), even when egg yolk and spinach were not effective (Stearns<sup>16</sup>).

Pablum, a palatable mixed cereal food, vitamin and mineral enriched, and cooked thoroughly and dried, consists of wheatmeal (farina), oatmeal, wheat embryo, cornmeal, powdered beef bone, sodium chloride, alfalfa leaf, brewers' yeast, and reduced iron. (The oatmeal form of Pablum is called Pabena.)

1-18 Bibliography on request.

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*Annual Meeting  
April 13-14—St. Petersburg*

# The JOURNAL *of the* Florida Medical Association, Inc.

Vol. XXX

APRIL, 1944

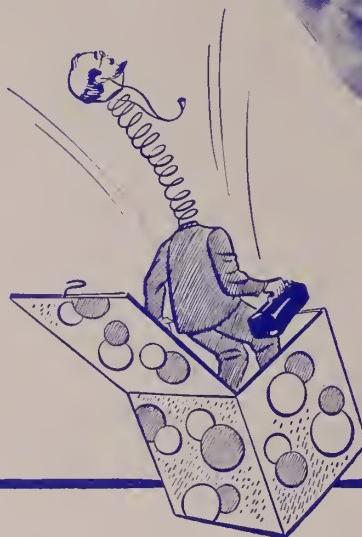
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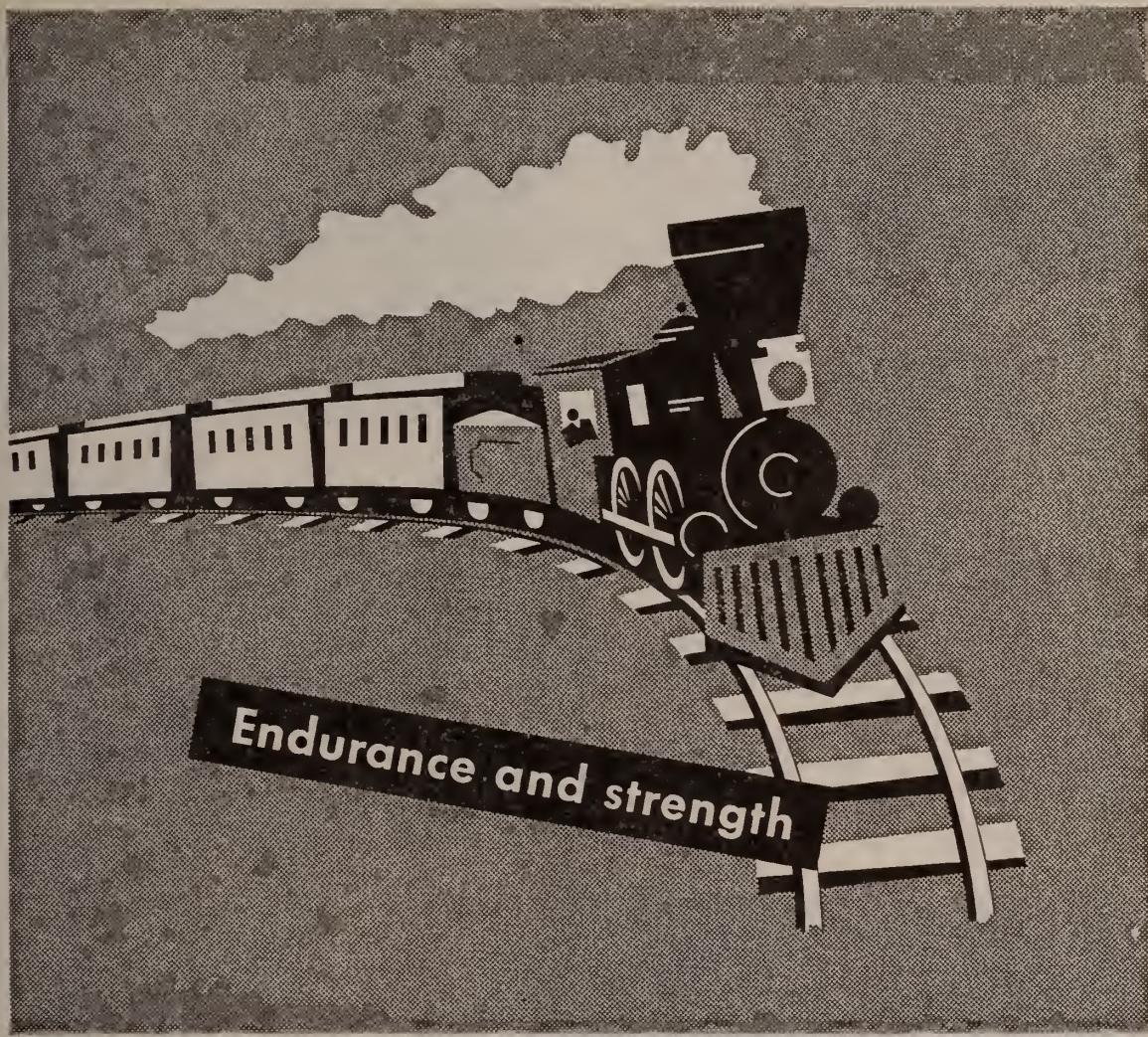
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## The Journal of the Florida Medical Association

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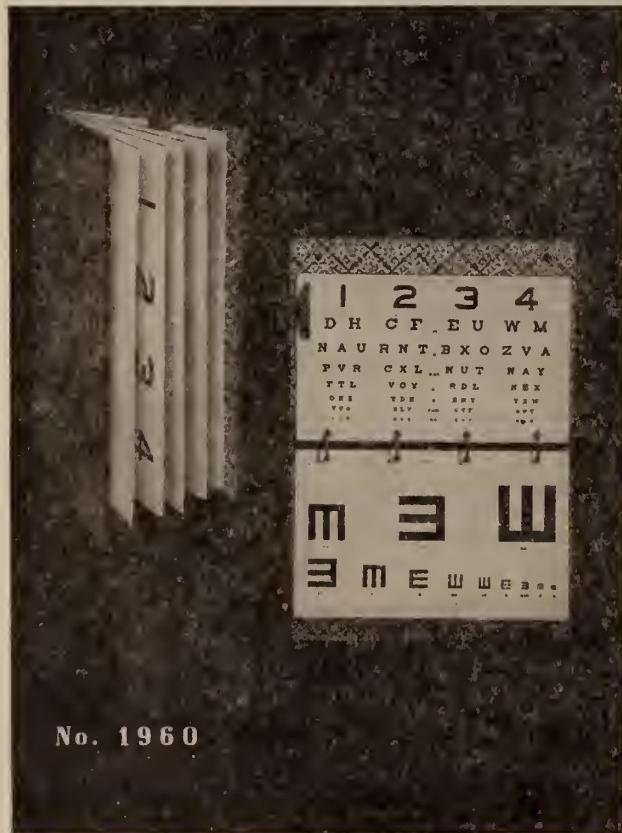
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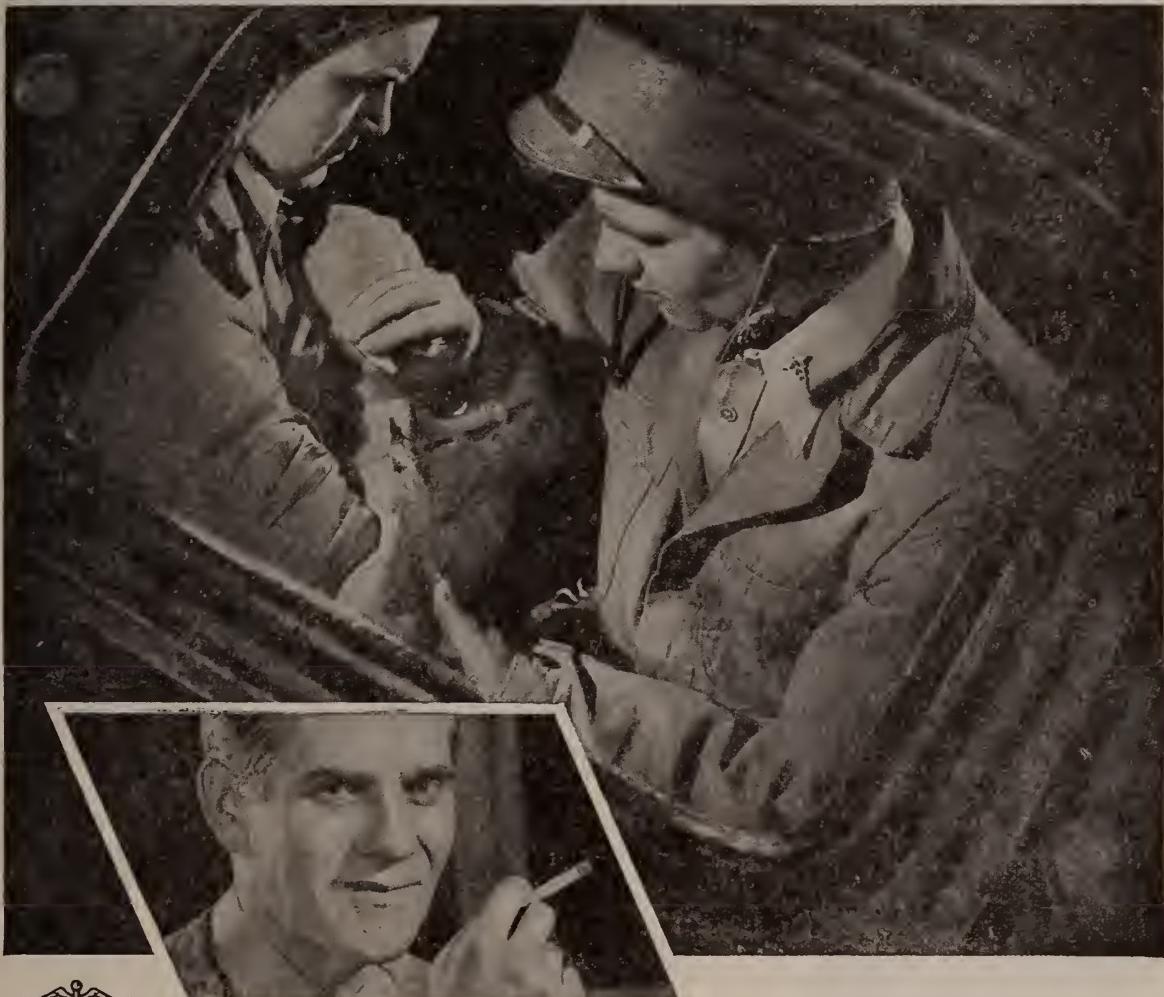


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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.



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On this point Pommerenke<sup>2</sup> recently made the following observation before the American Association of Industrial Physicians and Surgeons: "With a better understanding of the purpose and nature of menstruation, and its recognition as physiological rather than as a pathological process, many a woman may be re-educated and come to regard the so-called difficult days as days in which she need not seriously curtail her usual activities."

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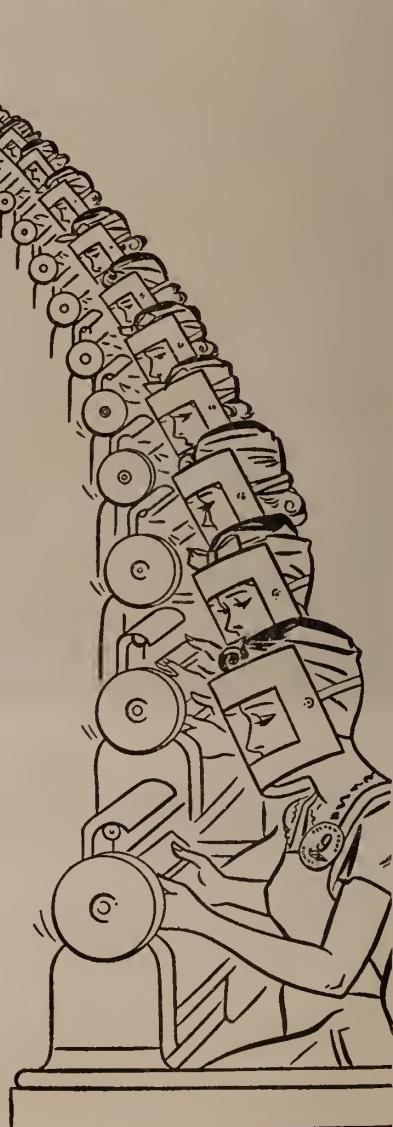
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(1) Mod. Med., 11:130, 1943; (2) Ind. Med., 12:512, 1943

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MILITARY MEN<sup>1</sup> writing on wartime anesthesia state that a heavy solution of Nupercaine\* (1:200) affords anesthesia of long duration with no circulatory disturbances in their series. Furthermore, they note that Nupercaine Hydrochloride is highly useful for rectal operations and serves admirably for high abdominal anesthesia.

As a spinal anesthetic, Jones solution (Nupercaine 1:1500)—which is receiving enthusiastic acclaim by the British—may be used in the management of thoracic war injuries<sup>2</sup>.

## NUPERCAINE *a long-acting anesthetic*

<sup>1</sup>Clement, F. W.; Elder, C. K.: Anesthesiology, 4:516, September, 1943.

<sup>2</sup>Forsee, J. H.; Shefts, L. M.; Burbank, B.; Fitzpatrick, L. J.; Burford, T. H.: J. Lab. & Clin. Med., 28:418, January, 1943.

\*Trade Mark Reg. U. S. Pat. Off. Word "Nupercaine" identifies the product as alpha-butylaxycinchoninic acid gamma-diethylethylenedioimide hydrochloride.



# Ciba

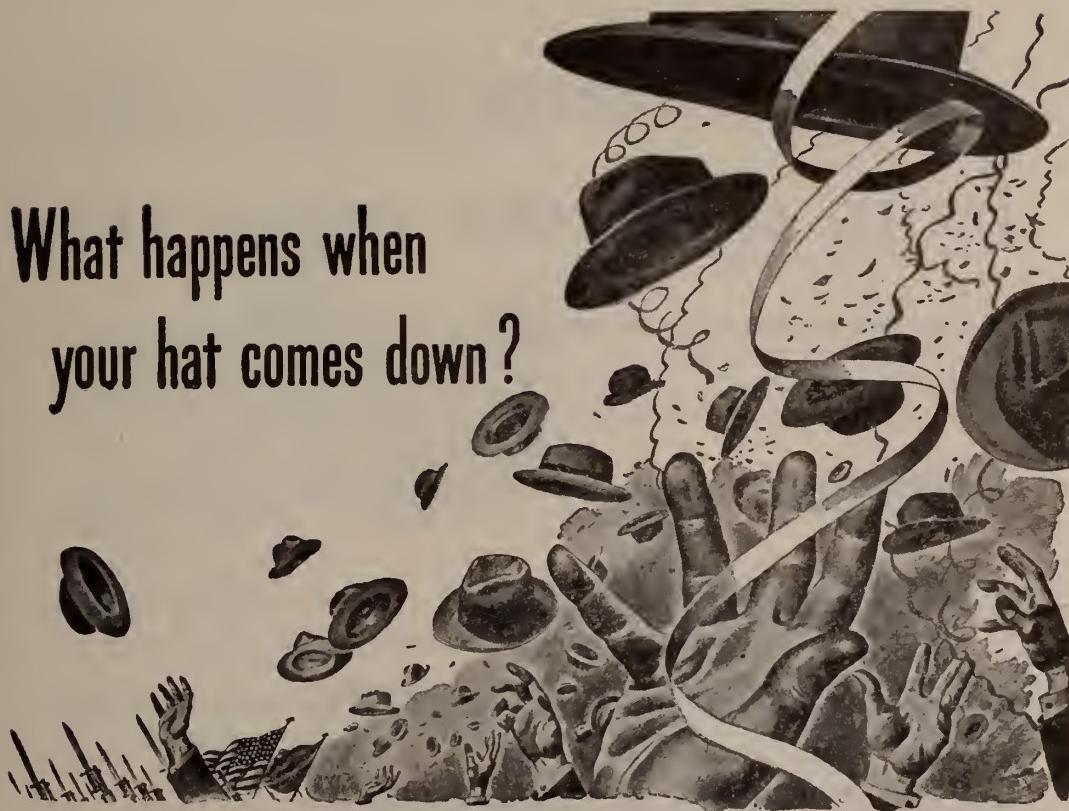
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—made by the ordinary method

**5 Edema 2.7** Popular cigarette #3  
—made by the ordinary method

**6 Edema 2.7** Popular cigarette #4  
—made by the ordinary method

**CONCLUSION:**\* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

**CLINICAL CONFIRMATION:**\*\* When smokers changed to PHILIP MORRIS, every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

\*N. Y. State Journ. Med. 35 No. 11,590 \*\*Laryngoscope 1935, XLV, No. 2, 149-154

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- Also useful for the purpose of suppressing lactation, under certain conditions

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CALCIUM . . . . .	.25 Gm.	1.104 Gm.	RIBOFLAVIN . . . . .	.25 mg. 1.278 mg.
PHOSPHORUS . . . . .	.25 Gm.	.903 Gm.	NIACIN . . . . .	5.0 mg. 6.9 mg.
IRON . . . . .	10.5 mg.	11.94 mg.	COPPER . . . . .	.5 mg. .5 mg.

\*Each serving made with 8 oz. of milk; based on average reported values for milk.



*He's such a  
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**COMPOSITION**

Dextrins . . .	75%	Mineral Ash . .	0.25%
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115 calories per ounce			
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*Literature on request*

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Ehrlich's prophetic vision of the "magic bullet" which would combine deadly efficacy against pathogenic bacteria with perfect compatibility in the human organism, approaches fulfillment in penicillin. Contrary to Ehrlich's expectation, this magic bullet is not a synthetic drug developed by a chemist—it results from the metabolism of a mold. Biologic production of a chemotherapeutic agent thus is now applied in the pharmaceutical field, a new approach.

Instead of the pure rationale of chemical formulas, the life habits of a microorganism are the controlling factor in the manufacture of penicillin; the chemist's important function here consists of guarding his microbial "workmen" and leading them to maximal production.

It is this type of work in which Commercial Solvents Corporation has been engaged since its beginning. For a quar-

ter century, the life habits of bacteria and molds have been the study to which an ever increasing number of scientists in the C. S. C. Research Laboratories are devoting their lives. From their studies have come valuable products, such as butanol, acetone, vitamins, etc., achieved by exacting standards of sterility, an extremely important factor in the working of the highly sensitive microorganisms. What other manufacturer of any kind in the United States has had comparable experience in the application of microbiologic methods to mass production?

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product upon the integrity of which the physician so often may have to stake his patients' lives. Rigid laboratory controls assure for Penicillin-C. S. C. uniform potency, sterility, and freedom from pyrogens.

Thus Commercial Solvents Corporation brings to the manufacture of penicillin not only outstanding production facilities, but also the knowledge born of a quarter century of research and actual experience, in a field not only difficult but largely unexplored by the pharmaceutical industry in general.

The capacity of the C. S. C. penicillin plant is conservatively rated at 40,000,000,000 (forty billion) Oxford Units per month. But for the time being its entire production must go to our armed forces. When their needs are met, Penicillin-C. S. C. will be available for civilian medical practice, not only in adequate distribution throughout the United States, but also at the reasonable cost to the patient which is every physician's desire, and which is made possible by C. S. C. volume production.



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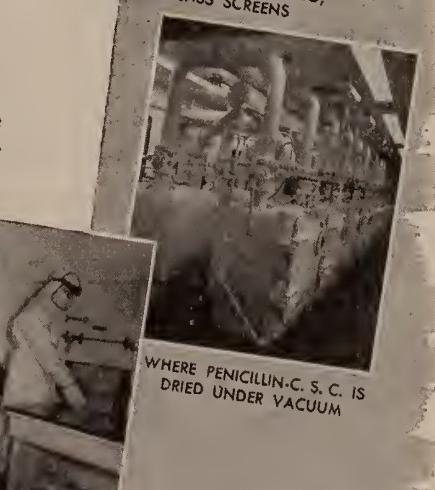
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AIR IN STERILE AREA



NOTE MASKS, STERILE CLOTHING,  
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WHERE PENICILLIN-C. S. C. IS  
DRIED UNDER VACUUM

ut so far I have learned of no other suggestion which provides the necessary valve which such an arrangement would give. It would be tragic if a lot of business concerns were wrecked and workers thrown into idleness because of inability to cut through the red tape in getting their claims settled.

#### RESPONSIBILITIES OF CONTRACTORS

In making these statements with regard to action by the Federal authorities, I realize, also, that business concerns which war contracts have a responsibility on part to facilitate speedy settlement of terminated war contracts. They have the responsibility for preparing their claims early and speedily and presenting them in form. Some progress has been toward getting a recognition of the fact that industry must play in this respect, but more and more experience of sort is now being gained. The consulting services of the Government, I know, very helpful attitude toward this situation, and the local office of W. P. B. has set up a regional advisory service for war faced with problems resulting from termination. That is a very helpful point.

Action to make possible the prompt settlement of terminated war contracts is now. It will be unsafe to wait until there is a deluge of contract terminations to through legislation on short notice. Problem is too complicated to be dealt effectively in that way.

#### MATERIALS FOR CIVILIAN PRODUCTION

In addition to making provision for the settlement of terminated war contracts, there is the task of facilitating the flow of materials for civilian production as soon as materials can be spared from war purposes. I hope that we shall not have unemployment here in Massachusetts because of materials, which are physically in use in the United States, are unavailable by manufacturers as a result of legal or administrative restrictions. The legislation vesting the priority power in President, which power of the President is delegated to the Chairman of the War Resources Board, is probably adequate to the flow of materials, but it may be for the Congress to make sure that administration of the priority power by War Production Board is directed effectively toward the speedy and smooth resumption of civilian production. The War Production Board should be expected to eliminate limitation orders, its conservation and its allocation systems just as to the needs of the war program per-

use of their effects on plans for reemployment. I foresee that these problems involving canceled contracts and securing supplies of raw materials for civilian production will presently be matters of wide concern here in Massachusetts. To summarize, my specific recommendation is that legislation should be enacted in the following points:

**MENT OF TERMINATED WAR CONTRACTS**  
Terminated contracts should be settled by negotiation by the contracting agency and the Government, and the negotiated settlement should be final in the absence of misrepresentation.

Partial payments amounting to a large percentage of the claim should be made to each contractor upon a submitted statement of the claim, subject to a penalty for perjury.

Local settlement committees should be authorized to make partial payments if delay of over 30 days occurs on the part of the Government agency.

Contracting agencies should be required to give prompt clearance of claims on work in process. There should be clear-cut procedures for authorizing the removal of Government-owned inventories and machines, with storage at Government expense, in order that civilian production may be started.

The dilemma of the subcontractors must be resolved. At the present time the Government exercises the right of approving all payments in settlement of subcontracts but does not assume any responsibility to the subcontractor, with the result that the subcontractor in many cases cannot secure action by either the prime contractor or the contracting agency. I suggest that the local settlement committees proposed above should be empowered to approve settlement of subcontracts if a delay occurs in approval by the contracting agency.

#### B. DECONTROL OF MATERIALS

As soon as war conditions permit, the rules for the release of scarce raw materials should be revised, with a view to facilitating the rapid resumption of civilian production.

### A Magnificent Job

#### EXTENSION OF REMARKS OR

#### HON. LOUIS LUDLOW

OF INDIANA

#### IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 11, 1944

Mr. LUDLOW. Mr. Speaker, Indianapolis and Indiana are very proud of the great pharmaceutical house of Eli Lilly & Co., which has processed its millionth blood donation without a cent of profit. This record is in keeping with the fine, generous spirit which this firm always has manifested in the service of our country and which long ago brought to it the recognition of an Army-Navy E award. Commenting on the company's contribution to the blood campaign, which means so much in saving the lives of our precious boys, the Indianapolis News says editorially:

#### LILLY'S CONTRIBUTION

In the midst of charges that some concerns are making an unboley profit from war contracts it is heartening to learn that the Indianapolis laboratories of Eli Lilly & Co. have processed 1,000,000 blood donations entirely on a nonprofit basis.

In addition to performing this service at cost, the expense involved has been decreased constantly through the introduction of more efficient methods.

There certainly could have been nothing unethical if the Indianapolis pharmaceuticals had sought a minimum profit for the work it has been doing.

Donations of blood at Atlanta, Chicago, St. Louis, Detroit, Cincinnati, Louisville, Columbus and Indianapolis have been converted into life-saving plasma at the Lilly plant, involving the installation of new equipment and the employment of much additional skilled personnel.

The patriotic Americans who donated this blood, however, got nothing for their contributions and the Lilly Co. determined that its connection with the effort to strengthen the wounded on every fighting front should be entirely shorn of private gain. From beginning to end, it has been and is—a magnificent job.

#### The Gates Must Not Be Closed

#### EXTENSION OF REMARKS OR

#### HON. SAMUEL DICKSTEIN

OF NEW YORK

#### IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 11, 1944

Mr. DICKSTEIN. Mr. Speaker, leave to extend my remarks in the ORD, I include the following editorial in the Daily Mirror of January 4, 1944:

#### THE GATES MUST NOT BE CLOSED

When Congress reconvenes on January 15 it should take up the Gillette-Taft-Bald Rogers resolution.

This resolution calls for the formation of a Presidential commission to create misery, in conjunction with the United Nations, to rescue the millions of Jews are now being systematically exterminated by the Nazis and their quislings.

When the Presidential commission is formed, one of the first things it should do to seek the abrogation of the "White Paper" of May 1939.

At present, Palestine is being administered by Great Britain in conformity with the policy embodied in the "White Paper," the effect of which Jewish immigration into Palestine is now limited and is to be stopped after March 31, 1944. The limit is to be reduced to a permanent minimum of 3 percent in the country and the land to Jews is to be practically pro-

#### A DIRECT REPUDIATION

This is a direct repudiation on England's part of the League of Nations Mandate of the Balfour Declaration incorporated in the mandate of 1917.

According to this declaration, Palestine was to become a national Jewish home under the protection of England.

In 1939, after the Jews had created a new civilization in what was practically a desert, England turned her back on her solemn promise of 1917.

This perfidy of Britain toward the Jews was deplored by no one more vigorously than by Winston Churchill in Parliament during the debate on the "White Paper" when he said:

#### MR. CHURCHILL'S REGRET

"As one intimately and responsibly concerned in the earlier stages of our Foreign policy, I could not stand by and see engagements into which Britain has been drawn before the world set aside for reasons of administrative convenience or for the quiet life. I should feel personally reassured in the most acute manner if myself by silence or inaction to what regard as an act of repudiation."

"I regret very much that the pledged Balfour Declaration, endorsed as it is by successive governments, and the obligations under which we obtained the mandate, have both been violated by the Government."

"I select one point upon which plainly a breach and repudiation of the Declaration—the provision that immigration can be stopped in 5 years by the decision of an Arab majority—is a plain breach of a solemn obligation."

"As the Palestine Mandate was ordered by the League of Nations, it cannot be abrogated even by Great Britain herself without the consent of the League."

#### A SOLEMN OBLIGATION

But the League did not give its consent to the 1939 abrogation.

# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

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No. 10

## THE TREATMENT OF CREEPING ERUPTION WITH FUADIN

J. FRANK WILSON, M. D.  
JACKSONVILLE

The treatment of creeping eruption has always been unsatisfactory, both from the patient's standpoint and that of the physician. In the past all methods of treatment were of a local nature and were designed to kill the larva by chemical means, suffocation, surgical removal and blistering, or by keratolytic lotions, plasters and ointments. There were even attempts made to inject substances hypodermically along the track to kill the larva in situ. Among these substances were ether, chloroform, iodine and even phenol. Needless to say, these measures were painful and ineffective, and they often caused sloughs.

Up to the time of the investigations by Kirby-Smith, White and Dove, a number of affections of the skin were classified as creeping eruption. In this paper creeping eruption refers strictly to the type caused by the *Ancylostoma braziliense*, which is the larva of a hookworm, and its host is almost always the cat, although some dogs have been found to be carriers. It is not definitely known how long this disease has been present in this country. It is much more prevalent along the coastal regions of the Gulf of Mexico and the south Atlantic than in other parts of the country. This distribution probably indicates that the disease was imported from the tropics and is of comparatively recent origin.

Since the discovery of the cause of this particular type of creeping eruption, a great many efforts have been made to find some effective remedy, but most forms of treatment have had serious drawbacks. All of the methods mentioned effect a cure in a certain percentage of the cases, but all of them are unsatisfactory for one reason or another. Most of them have to be repeated many times, and when the patient is infested with a large number of larvae, the treatment is of long duration, during which time it is impossible to relieve him from the almost intolerable itching. In addition, it is necessary to treat the skin that has been injured by the chemicals, surgical procedures, or whatever treatment has been employed.

The most satisfactory method in the past

was freezing by ethyl chloride. This is efficient when there are only one or two lesions with no excoriations or secondary infection. The end of the burrow is easily seen, and if a large area around it is frozen solidly for at least three minutes, the larva will, in most cases, be killed. When sufficient ethyl chloride is used to kill the larva, it causes a blister which has to be treated soothingly. When there are large numbers of larvae present, there are always excoriation and secondary infection, and tracing out each burrow is difficult, if not impossible. In these cases freezing has to be done almost by guesswork, as frequently the larva doubles back and goes in the direction from which it came. Another fact not generally recognized is that the burrow does not show up for about twelve hours, and the larva may be one-half inch in any direction from the visible burrow.

Not the least objection to the use of ethyl chloride is its cost. Metal tubes are the only efficient ones, and frequently when large areas are treated, as many as ten tubes are used in one treatment. Thus the cost of the ethyl chloride alone is \$15. In some cases the amount required to effect a cure is worth from \$200 to \$300, and in addition there is the tedious work of applying it.

The first record of successful systemic treatment of this disease, as well as the first record of the use of fuadin as a remedy, appears to be in an article by Smith, of Charlottesville, in the Journal of the American Medical Association of Nov. 13, 1943. Unfortunately, the peak of the season for larva migrans is in August, tapering off in September, and thereafter only sporadic cases occur. In consequence, my attention was first directed to this therapy too late in the year to permit treatment of more than a limited number of cases. I hope to have a large number to report in the fall of 1944. This report covers only 7 cases.

Smith recommended treatment with five doses of fuadin at daily intervals, this course to be repeated after one week. He mentioned that there were no symptoms after the first injection; so it appears likely that the larva was killed and that the subsequent injections were unnecessary. It is to be remembered that the injection should be

made deep in the upper, outer quadrant of the gluteal muscle, and not near the site of the infection. In the first case of this report, five injections of 5 cc. each were given to an adult with no itching after the first dose. So, it was decided to use only one dose in the treatment of subsequent cases, for the idea has always been to find a remedy which acts quickly and is less painful as well as less expensive than those previously used. In 5 cases no further treatment whatever was needed, but in 2 cases a second injection was required. The larva showed signs of activity after lying dormant for seven days in 1 case and eight days in the other.

The size of the dose was not determined with accuracy, 2 cc. being administered to a baby of thirteen months, and the amount of the dose was then graduated up to 3½ cc. in a child of eight years. In no case was there an untoward reaction. There are apparently no contraindications to the use of fuadin, and in the doses used it is practically nontoxic. With prolonged administration, using gradually larger doses, there develop stiffness of the muscles, slight nausea and sometimes diarrhea, in which case subsequent doses are simply reduced below the point of reaction and the drug is not discontinued. In 1 case under my observation, in which, incidentally, there was the most extensive infestation with larvae I have ever seen, the patient also had an alcoholic hepatitis and was subject to asthma; so the drug was not used, for I did not know what effect it would have on his general health. In the usual case, when the patient is apparently in good health, there should be no hesitancy in giving the full dose at once, providing due regard is given to the patient's age, for the large majority of cases occur in babies and children. If one dose can effect a cure, or at most two doses a week apart, then a slight reaction is of no consequence and will pass off in a short time without the administration of an antidote. If diarrhea occurs, it can be controlled with small doses of paregoric.

The finding that fuadin is effective in such dissimilar diseases as granuloma inguinale, larva migrans and Vincent's stomatitis suggests that it has a large field of possibilities in diseases of protozoal origin. Some of these diseases are resistant to any known form of treatment, and some have resisted all forms of treatment.

Locally, ethyl acetate collodion was used for two reasons. In the first place, it gives temporary relief from the itching and may be applied

as often as desired. In the second place, it precludes the use of other remedies which are being used, or may be suggested, by others. Some of these remedies may be irritating, whereas the collodion forms a coating which is protective and allows healing.

#### SUMMARY

Fuadin appears to be a specific in the treatment of larva migrans. In the majority of cases one dose is sufficient. This practically eliminates the possibility of antimony poisoning. It is probable that the employment of fuadin in all cases, indiscriminately, will give rise to a number of objections to its use, but, as stated, this is only a preliminary report, and fuadin has certainly proved itself worthy of trial.

415 Greenleaf Bldg., zone 2.

### THE ROLE OF FLUIDS ADMINISTERED ORALLY IN CAUSING POSTOPERATIVE DISTENTION FOLLOWING CESAREAN SECTION AND GYNECOLOGIC OPERATIONS

REPORT OF 100 CASES

B. F. HART, M. D.  
WINTER PARK

The effect of fluids administered orally to the freshly operated patient is often not appreciated. It is the custom of many surgeons to allow ice chips and cold water soon after the operation.

In this study of 100 cases roughly three fifths of the patients received some form of fluids orally within the first twelve hours after the operation while the remainder received nothing orally for twenty-four hours. Forty-nine of this group were subjected to cesarean section and the remainder to various types of gynecologic operation. Both classical and low cervical operations are represented as well as a few cesarean hysterectomies. The cesareanized patients were more likely to become distended when given fluids orally than were the gynecologic patients similarly treated.

An arbitrary standard of classification by which the patients were graded was adopted as follows: Patients with anything above a flat abdomen were classed as slightly distended; patients in whom there developed a rotund abdomen or bulging around the bandages were classed as moderately distended; patients in whom the abdomen became tense were classed as greatly distended.

The small group who received ice and ice

water had considerably more distention than those who were given water at room temperature or warm water. This result was in keeping with recent studies on animals. The physiologists have shown that alimentary activity can be retarded by cold fluids and accelerated by hot fluids. In this series, however, a few patients who were allowed a liberal quantity of warm fluids tended to become distended. This distention might be explained by the fact that the digestive tract exhibits little activity for from twenty-four to forty-eight hours after a major pelvic operation and responds poorly to any form of stimulant. Also, in taking the water these patients probably swallowed a considerable amount of air, which accumulated in the atonic bowel. Several of the patients who were given ice or cold fluids were also given the so-called prophylactic doses of prostigmine (1/4000 doses). They became as badly distended and required as much heroic treatment as the others.

Patients who received only hot water or tea did better than those who were given water at room temperature or cold water. This difference might be explained in two ways. Firstly, the hot fluids tended to stimulate the digestive tract rather than depress it; secondly, these patients usually did not care much for hot fluids and therefore drank less.

The group who received nothing by mouth for twenty-four hours seldom became distended and then usually to a mild degree. A moderate distention developed in 2, neither of whom required Wangensteen suction. One had peritonitis, and the other received liberal amounts of cool water the day following the operation. It is not easy to withhold fluids administered orally immediately after an operation if the hospital personnel has been accustomed to allow water following nausea. Strict orders are necessary, especially when a thirsty patient is continually asking for water.

Lately the plan adopted has been to give the patient 1,000 cc. of five per cent glucose in distilled water immediately after she returns from the operating room. This is helpful in relieving the intense thirst whereas a like amount of glucose in saline solution would intensify it. In from four to six hours 1,000 cc. of five per cent glucose in saline is given. The patient usually receives a second 1,000 cc. of five per cent glucose in distilled water in the evening. There is seldom much complaint of thirst during the first postoperative night. The morning following the op-

eration hot water and hot tea are usually allowed in limited amounts. During the second twenty-four hours after the operation the average patient receives 1,000 cc. of five per cent glucose in saline and an equal amount of glucose in distilled water. If the loss of fluid has been considerable, either by sweating or by the alimentary tract, the amount of fluids administered parenterally may need increasing. In most cases a liquid diet is given the second postoperative day. In complicated cases the patient may receive most of the fluid intake by the parenteral route for several days postoperatively.

From more recent cases that are not included in this study it appears that with patients who have had considerable intraabdominal trauma, as in extensive endometriosis or multiple adhesions from old infectious processes, oral fluids can often be omitted to advantage for forty-eight hours or longer.

If distention is prone to develop, it is usually manifest by the second postoperative day. By this time the bowel has often recovered sufficiently to respond to enemas and stimulants like pitressin and prostigmine. In severe cases of distention the Wangensteen suction is usually applied.

In peritonitis there is a tendency to some distention even when no fluids are allowed orally, but this condition is worse if the patient is given fluids by mouth.

In this series a variety of anesthetic agents was employed. About half of the group received some form of inhalation anesthetic, and to the remainder the anesthetic was administered spinal, intravenously, or locally. Those who received a general anesthetic appeared more prone to become distended if they were allowed fluids orally.

Most of the patients were given an enema on the second or third postoperative day. If the enema was not promptly expelled, an ampule of 1/2000 prostigmine or 1/2 cc. of pitressin was usually given. In some instances this treatment was repeated more than once for it tends to shorten the period of annoying gas pains that occurs when the lower bowel begins to resume activity as well as to alleviate distention. Some patients were allowed soft foods on the afternoon of the second postoperative day, which served the dual purpose of furnishing nutrition and stimulating peristalsis.

As preoperative medication the average pa-

tient received a barbiturate the night before and the usual dose of 1/6 to 1/4 grain of morphine with 1/150 grain of atropine the morning of the operation, except the cesareanized patients, who received only atropine before going to the operating room and morphine after the baby was delivered. Postoperatively, most of them received 1/6 to 1/4 grain of morphine every four hours for six doses, then every four hours only if needed.

#### ANALYSIS OF RESULTS

Patients who received cold water and ice soon after the operation:

Great Distention .....	7
Moderate Distention .....	10
Slight Distention .....	0
No Distention .....	0
—	17

Patients who received water at room temperature soon after the operation:

Great Distention .....	3
Moderate Distention .....	5
Slight Distention .....	11
No Distention .....	3
—	22

Patients who received warm water soon after the operation:

Great Distention .....	2
Moderate Distention .....	0
Slight Distention .....	8
No Distention .....	12
—	22

Patients who received nothing orally for twenty-four hours after the operation, then hot water and hot tea during the next twenty-four hours:

Great Distention .....	0
Moderate Distention .....	2
Slight Distention .....	9
No Distention .....	28
—	39

GRAND TOTAL..... 100

#### CONCLUSIONS

Patients who were allowed fluids orally soon after the operation were prone to become distended, and the colder the fluids the greater the distension.

Patients who received nothing by mouth for

at least twenty-four hours and then hot fluids for twenty-four hours did not often become distended and then usually to a slight degree.

The intense thirst that ordinarily occurs after surgical procedures can usually be alleviated by giving an average of 2,000 cc. of five per cent glucose in distilled water in divided doses during the first twenty-four hours. In most instances the glucose in saline for the same period can be limited to 1,000 cc. The total amount of fluids administered parenterally may need increasing if there has been excess sweating or loss of fluid through the alimentary tract.

Bowel stimulants are of questionable value in preventing distention. In most cases the bowel responds poorly to any form of stimulant during the first twenty-four to forty-eight hours following an operation; however, after this time pitressin or prostigmine in conjunction with enemas usually relieves distention and shortens the period of annoying gas pains that ordinarily occurs when the bowel begins to resume activity.

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157 New England Avenue.

## Don't Miss The ANNUAL CONVENTION

St. Petersburg

April 13 and 14, 1944

Princess Martha Hotel

## ABSTRACTS OF MEDICAL ARTICLES

LEUKEMOID REACTION (HYPERLEUKOCYTOSIS) IN MALIGNANCY, MEYER, LEO M., AND ROTTER SAUL D., BROOKLYN, N. Y., AM. J. CLIN. PATH. 12: 218-222 (APR.) 1942.

In 2 cases reported, the leukemoid blood picture, resembling that of leukemia although not caused by the same type of change in the formative tissues, was associated with malignant disease of the stomach. In the case of a white man aged 66, the initial study of the blood showed a hemoglobin estimation of 30 per cent, a red blood cell count of 1,580,000 and a white blood cell count of 110,000 with 94 per cent polymorphonuclear neutrophils, 4 per cent lymphocytes and 2 per cent myelocytes. In the blood smears numerous normoblasts were observed. Subsequent examinations of the blood indicated a persistent secondary anemia. The leukocyte count varied from 72,000 to 110,000 with the polynuclear count ranging between 91 and 98 per cent. At autopsy, the diagnosis of adenocarcinoma of the stomach with localized peritonitis was confirmed.

In the second case the patient was a white woman aged 42. Examination of the blood at the time of her admission to the hospital showed a hemoglobin estimation of 75 per cent, red blood cells 4,125,000 and white blood cells 66,250 with 78 per cent segmented polymorphonuclears, 11 per cent band forms, 9 per cent myelocytes and 2 per cent lymphocytes. Ten days later the white blood cell count was 128,000 with 58 per cent lobed neutrophils, 23 per cent band forms, 13 per cent myelocytes and 2 per cent myeloblasts; shortly before death on the seventeenth day it was 198,000 with 15 per cent myelocytes and 73 per cent segmented and nonsegmented forms. Findings at autopsy established a diagnosis of anaplastic carcinoma of the stomach with metastases to the liver, spleen and abdominal lymph nodes.

In both cases, although pronounced quantitative changes in the blood were present, the white cells were almost entirely of the mature type. These cases are cited as demonstrating that the unknown factor responsible for the hyperleukocytosis obviously differs from the maturation factor in the bone marrow, an observation more clearly demonstrated in the leukemoid reaction because in this state the total white blood cell count may not be increased, but a decided

shift to the left takes place. The absence of metastasis to the bone marrow is noteworthy in these cases.



CONTROL OF MASSIVE PULMONARY HEMORRHAGE BY PNEUMOPERITONEUM, LOGIE, ARTHUR J.; WALKER, HARRISON A., AND STODDARD, GUY R., MIAMI BEACH, ANN. INT. MED. 19: 685-690 (OCT.) 1943.

A case is reported in which pneumoperitoneum was used with dramatic effect in the treatment of massive pulmonary hemorrhage. Although this procedure has been successfully employed to control repeated small hemoptyses, its use in the treatment of this type of case had apparently not previously been reported.

During the first thirty days of hospitalization the patient, a white man aged 25, had 19 hemorrhages, 16 of them massive, and lost over 6,000 cc. of blood. In this period he received approximately 5,000 cc. of blood in 13 transfusions. On the tenth day artificial pneumoperitoneum was induced, and, in all, 14 pneumoperitoneum refills were administered, making a total of about 14,500 cc. of air. It became necessary to inject daily approximately 1,000 cc. of air in order to maintain the intraperitoneal pressure at plus 16 mm. to plus 18 mm. of water. Despite this therapy, no complications occurred.

Moderate discomfort caused by the great degree of abdominal distention was the only untoward effect of maintaining the exceedingly high intraperitoneal pressure and was usually relieved by elevating the foot of the patient's bed. Without doubt, the authors concluded, the pneumoperitoneum was effective in controlling the pulmonary hemorrhages.

The patient had an uneventful recovery. At the time of discharge, nine weeks after admission, he was referred to the Chevalier Jackson Clinic for further study in preparation for lobectomy. At that time his temperature had been normal for one month, and examination of the blood gave normal results. Roentgen examination showed elevation of the diaphragm to the level of the lower border of the ninth rib, complete resolution of the shadow at the base of the right lung, and a well aerated left lower lobe. There was still a partial pneumoperitoneum with the intraperitoneal pressure equaling plus 3 mm. of water.

# WAR PROGRAM

## SEVENTY-FIRST ANNUAL MEETING

*of the*

## FLORIDA MEDICAL ASSOCIATION

TO BE HELD AT ST. PETERSBURG, FLORIDA  
APRIL 13 and 14, 1944

### REGISTRATION

The registration desk will be located on the mezzanine of the Princess Martha Hotel with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests, ladies and exhibitors are required to register.

### HOTELS

PRINCESS MARTHA—*Convention Headquarters*  
(European Plan)  
Single—\$3.00 Double—\$5.00

Other (European Plan)	Single	Double
Detroit**	\$3.00	\$5.00
Bainbridge	3.00	5.00
Poinsettia	2.50	4.00
Dennis**	3.50*	5.00*
Pheil	2.50*	3.50*
Royal Palm	3.00	4.00
Pennsylvania**	3.00	6.00
Alexander	4.50*	6.50*

\*\*Meals available.

\*And up.

Lederle Laboratories, Inc.  
Eli Lilly & Co.  
M. & R. Dietetic Laboratories, Inc.  
The Maltine Company  
Mead Johnson & Company  
The William S. Merrell Company  
Maico Hearing Service  
Ortho Products, Inc.  
Parke, Davis & Company  
Pet Milk Company  
Schering Corporation  
Sharp & Dohme  
Southeastern Optical Company, Inc.  
Spencer, Inc.  
E. R. Squibb & Sons  
Standard X-Ray Sales Company  
Surgical Supply Company  
Tablerock Laboratories  
The Tower Co.  
Walker Vitamin Products  
White Laboratories, Inc.  
Wyeth, Inc.  
Zimmer Mfg. Company

### FIRST GENERAL SESSION

Thursday, 1:30 p. m.  
ASSEMBLY ROOM

- Call to Order, President Eugene G. Peek
- Invocation, The Reverend E. A. Edwards, St. Peter's Episcopal Church, St. Petersburg
- Special Announcement, J. A. Hardenbergh, President, Pinellas County Medical Society
- Gavel to First Vice President Louie Limbaugh
- President's Address, Eugene G. Peek, Ocala
- President resumes Chair
- Report of Secretary-Treasurer-Editor, Shaler Richardson, and Managing Director, Stewart Thompson
- Address (by invitation) "The Relationship of Obstructive Lesions to Urologic Affections," Edgar G. Ballenger, President-Elect, Southern Medical Association, Atlanta
- Introduction, delegates from other state societies
- New business
- Announcements
- Dr. W. C. McConnell, Chairman of a Special Committee

The following firms have arranged for exhibits at the St. Petersburg meeting:

American Optical Company  
Bard-Parker Company, Inc.  
Bilhuber-Knoll Corp.  
The Borden Company  
Camel Cigarettes  
S. H. Camp & Co.  
The Coca-Cola Company  
Endo Products, Inc.  
Everhart Surgical Supply Co.  
C. B. Fleet Company  
Jones Metabolism Equipment Co.  
Keleket X-Ray Company of Florida

#### REFERENCE COMMITTEES

All reference committees will meet immediately after the Scientific Assembly, Thursday evening, April 13, in this room. The names of delegates who have been appointed by President Eugene G. Peek to serve on reference committees are listed below:

##### 1. HEALTH AND EDUCATION RIGHT OF PLATFORM

Herbert E. White, *Chairman*  
Louie Limbaugh  
Homer L. Pearson  
H. Mason Smith  
R. H. Knowlton

##### 2. PUBLIC POLICY RIGHT REAR CORNER

Walter C. Jones, *Chairman*  
Edward Jelks  
Herman Watson  
Spencer A. Folsom  
Lloyd J. Netto

##### 3. FINANCE AND ADMINISTRATION LEFT OF PLATFORM

Shaler Richardson, *Chairman*  
Wiley M. Sams  
John R. Boling  
W. M. Rowlett  
W. C. McConnell

#### FIRST MEETING, HOUSE OF DELEGATES

Thursday, 3:30 p. m.  
ASSEMBLY ROOM

(Front seats reserved for delegates—other Association members please occupy seats in rear)

President Peek in the Chair

Roll Call and seating of delegates

Adoption of minutes as published in June, 1943 Journal

Recognition of Delegates to A. M. A.: Edward Jelks and Meredith Mallory. (*Official report read at meeting of Board of Governors and published in September 1943 Journal*)

Election of one delegate and one alternate to A. M. A. meeting for two-year terms. (*A. M. A. By-Laws, Chapter 1, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve."*)

President—Announce reference committee personnel

Reading of Resolutions

Meeting place, 1945

Report of Committees: (*Two copies of each report are to be laid on speaker's table immediately after reading*)

Board of Governors, Robert D. Ferguson  
Scientific Work, Herbert E. White  
Legislation and Public Policy, W. M. Rowlett  
Medical Education and Hospitals, Howard G. Holland  
Public Relations, Leigh F. Robinson  
Necrology, Gerry R. Holden  
Medical Postgraduate Course, T. Z. Cason  
Cancer Control, John N. Moore  
Medical Economics, Ferdinand A. Vogt  
Venereal Disease Control, E. T. Sellers  
Interrelationship, William M. Davis  
Tuberculosis and Public Health, William C. Blake  
State Controlled Med. Institutions, H. Mason Smith

Maternal Welfare, William C. Thomas  
Child Health, George L. Cook  
Conservation of Vision, Shaler Richardson  
Advisory to Woman's Auxiliary, George C. Tillman  
Representatives to Industrial Council, J. C. Davis  
Council, Lloyd J. Netto  
War Participation, Edward Jelks  
Board of Past Presidents, H. Marshall Taylor  
Publication, Herman Watson

#### New Business

#### Announcements:

Reference Committees and Board of Past Presidents will meet immediately after first scientific assembly in this room.

#### Adjournment

#### ASSOCIATION DINNER

Thursday, 6:30 p. m.  
PENNSYLVANIA HOTEL

Members and their ladies, Association guests, Exhibitors  
Informal. Dinner tickets, \$2.00

#### SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Herbert E. White, Chairman, St. Augustine; George A. Dame, Fernandina; J. R. Boulware, Lakeland; Homer L. Pearson, Miami; James H. Pound, Tallahassee.

Attention is called to the following By-Law:

*"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."*

#### FIRST SCIENTIFIC ASSEMBLY

Thursday, 8:00 p. m.  
ASSEMBLY ROOM

1. "Fundus Changes in Arterial Hypertension," Walter I. Lillie, Professor of Ophthalmology, Temple University, Philadelphia

Lt. Col. John R. Chappell, a member of the Florida Medical Association now serving as Chief of the Surgical Service at MacDill Field, Tampa, arranged for the following portion of this scientific program. All essayists and discussers are medical officers stationed at MacDill Field.

2. "Psychiatric Experiences in an Army Air Base Hospital," Captain Theodore L. L. Soniat, Chief of Section on Neuropsychiatry

Discussion: Captain Herbert E. Harms, Director of Mental Hygiene Unit

3. "Penicillin" (Exhibits: a. Growing Penicillin; b. Effects on Staphylococci), Captain Millard B. White, Director of Laboratories

Discussion: Captain Luverne R. Domeier, Pathologist  
Captain William F. McManus, Assistant Director of Laboratories

4. "Primary Atypical Pneumonia; Analysis of 150 Cases" (Lantern Slides), Captain Morris B. Guthrie, Chief of Section on Respiratory Diseases

Discussion: Major Richard Reeser, Chief of Medical Service  
Major Kenneth B. Watson, Chief of Roentgenological Service

## SECOND MEETING, HOUSE OF DELEGATES

*Friday, 9:30 a. m.*  
ASSEMBLY ROOM

Roll Call (*No alternates are to be seated for delegates attending yesterday's meeting*)

Recommendations of Reference Committees

- No. 1, Health and Education
- No. 2, Public Policy
- No. 3, Finance and Administration

Other unfinished business

New business

Announcements

Adjournment

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## SECOND SCIENTIFIC ASSEMBLY

*Friday, 10:30 a. m.*  
ASSEMBLY ROOM

5. "Refrigeration Anesthesia of the Extremities; Its Application, Use and Case Reports" (Lantern Slides), Duncan T. McEwan, Orlando

Discussion: William C. Blake, Tampa  
Lt. Col. Hrolfe R. Ziegler, Chief of Surgical Service, Orlando Air Base Hospital

6. "Gynecologic Problems Beginning of Forty," Lt. Comdr. Carroll J. Fairo, Diplomate American Board of Obstetrics and Gynecology; Instructor, Obstetrics and Gynecology, University of Cincinnati, Coast Guard Training Station, Palm Beach

Discussion: William M. Rowlett, Tampa  
Comdr. Ferdinand Richards, U. S. Naval Hospital, Jacksonville

7. "The Challenge of Tuberculosis to the Physician" (Lantern Slides), Henry C. Sweany, Director of Research and Laboratories, Chicago

Discussion: T. Z. Cason, Jacksonville  
M. Jay Flipse, Miami

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## SECOND GENERAL SESSION

*Friday, 12:00 noon*  
ASSEMBLY ROOM

President Peek in the Chair

Unfinished business

New business

Election of President-Elect

Election of First Vice President

Election of Second Vice President

Election of Third Vice President

Election of Secretary-Treasurer and Editor of the Journal

Dr. John R. Boling escorted to the Chair as new President

Presentation of Past President's Button to Dr. Eugene G. Peek by Dr. H. Marshall Taylor

Adjournment

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BOARD OF GOVERNORS will meet at 12:30 p.m.  
*Friday*

## SPECIALTY GROUP MEETINGS

SIXTH ANNUAL MEETING, FLORIDA SECTION  
AMERICAN COLLEGE OF PHYSICIANS

## OFFICERS

- R. H. Knowlton, President ..... St. Petersburg  
Kenneth Phillips, Secretary ..... Miami

*Thursday, April 13*

## YACHT CLUB

- 10:00 a.m. "Failure of Decision," Arnold S. Anderson, St. Petersburg  
10:30 a.m. "The Clinical Application of Vitamin B Complex," J. Sudler Hood, Clearwater  
11:00 a.m. "Pulmonary Edema," William C. Blake, Tampa  
11:30 a.m. Business Meeting and Election of Officers  
12:30 p.m. Luncheon (\$1.00)
- 

SIXTH ANNUAL MEETING  
FLORIDA SOCIETY OF OPHTHALMOLOGY  
AND OTOLARYNGOLOGY

## OFFICERS

- Shaler Richardson, President ..... Jacksonville  
R. E. Repass, Vice President ..... Miami Beach  
C. E. Dunaway, Secretary ..... Miami

*Thursday, April 13*

## ASSEMBLY ROOM

9:30 a.m. Scientific Session

1. "Conjunctival and Limbal Lesions of Diagnostic Importance," Lt. Col. Phillip Thygeson, Drew Field, Tampa
2. "Management of Traumatic Injuries of Facial Bones," Major Dillon Geiger, Miami Beach Training Base, Miami Beach
3. "Clinical Significance of Diplopia," Dr. Walter I. Lillie, Professor of Ophthalmology, Temple University, Philadelphia

12:00 noon. Business Meeting and Election of Officers

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SIXTH ANNUAL MEETING  
FLORIDA ASSOCIATION OF INDUSTRIAL  
SURGEONS

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A. M. Bidwell, Sec.-Treas. (Act.) ..... Tampa

*Thursday, April 13*

## DETROIT HOTEL (AMERICAN ROOM)

- 10:00 a.m. President's Address, Frank D. Gray, Orlando  
10:10 a.m. Secretary-Treasurer's Report  
10:30 a.m. Report of Fee Schedule Committee, A. M. Bidwell, Chairman  
10:50 a.m. Round Table Discussion  
11:30 a.m. Election of Officers  
12:00 noon Luncheon (\$1.00)

REGULAR QUARTERLY MEETING OF THE  
FLORIDA SOCIETY OF  
**DERMATOLOGY AND SYPHILOLOGY**

OFFICERS

Wiley M. Sams, President ..... Miami  
Lauren M. Sompayrac, Secretary ..... Jacksonville

*Thursday, April 13*

DETROIT HOTEL (ROOM No. 5)

11:00 a.m. Round Table Discussion

11:30 a.m. Business Meeting

11:50 a.m. Election of Officers

12:00 noon Luncheon (\$1.00)

THIRTEENTH ANNUAL SPRING MEETING  
**FLORIDA RADIOLOGICAL SOCIETY**

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Walter A. Weed, Acting Sec.-Treas. ..... Orlando

*Thursday, April 13*

PHEIL HOTEL (ROOM 203)

9:30 a.m. Round Table Discussion

11:30 a.m. Business Meeting and Election of Officers

THIRD ANNUAL MEETING  
**FLORIDA PATHOLOGICAL SOCIETY**

OFFICERS

L. Y. Dyrenforth, President ..... Jacksonville  
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Iva C. Youmans, Secretary ..... Miami  
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*Thursday, April 13*

PHEIL HOTEL (ROOM 205)

11:00 a.m. General Session and Election of Officers

EIGHTEENTH ANNUAL MEETING  
**WOMAN'S AUXILIARY**

OFFICERS

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REGISTRATION

Ladies are requested to go directly to the registration desk at the Princess Martha Hotel for their official badges and programs. Admission to the Army and Navy Club is by badge only.

PROGRAM

*Friday, April 14*

ARMY AND NAVY CLUB

9:00 a.m. Pre-Convention Board Meeting

9:30 a.m. General Auxiliary Session

1:00 p.m. Luncheon

BUY WAR BONDS

## FLORIDA MEDICAL ASSOCIATION OFFICERS AND COMMITTEES

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EDWARD JELKS, M.D., Delegate.....	Jacksonville
O. O. FEASTER, M.D., Alternate.....	St. Petersburg
(Terms expire Dec. 31, 1944)	
HOMER L. PEARSON, M.D., Delegate.....	Miami
GEORGE C. TILLMAN, M.D., Alternate.....	Gainesville
(Terms expire Dec. 31, 1945)	

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GILBERT S. OSINCUP, M.D., 1942.....	Orlando

\*Alternate for member in Armed Services.



EDGAR G. BALLINGER, M. D., OUR GUEST OF HONOR

Edgar Garrison Ballenger was born in Tryon, North Carolina, November 20, 1877. He attended Furman University and the University of North Carolina and then matriculated at the Medical School of the University of Maryland, from which he was graduated in 1901. The following year he served as intern at the University of Maryland Hospital, and was then company surgeon for the Maryland Granite Company at Guilford, Maryland, for one and one-half years. He began the practice of urology in Atlanta in 1904, which he has continued to the present time.

Dr. Ballenger has been president of the American Urological Association, the Southeastern Section of the American Urological Association, the Southeastern Surgical Congress, and is now president-elect of the Southern Medical Association.

As a pioneer in urologic work in the southeast, he has been a frequent contributor to current medical journals.

**The Journal of The Florida Medical Association**

Owned and published by Florida Medical Association, Inc.

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**SEVENTY-FIRST ANNUAL MEETING**

In this month's Journal appears the complete program of the Association's annual convention, scheduled for St. Petersburg, Thursday and Friday, April 13 and 14. The headquarters hotel will be the Princess Martha. Other hotels where rooms may be available are listed in the program. Room reservations should be made as early as possible.

The scientific program has been carefully prepared by Dr. Herbert E. White, committee chairman, and his associates. Every physician who finds it possible to attend will be well repaid as essayists and discussers have been chosen who are outstanding in their fields.

The convention will be streamlined because of the war effort, and will occupy only one and one-half days. Careful preparations have been made, however, to give our members the most comprehensive program possible during this short time.

On Thursday forenoon specialty group meetings will be held. Six groups have completed arrangements for annual meetings, and their programs, also, are published. These specialty meetings are of great importance and increase the value of the convention.

Technical exhibits should be of unusual interest to attending physicians this year. The exhibit hall will be open early Thursday morning.

**NOTICE TO DELEGATES AND COMMITTEE CHARMEN**

The first meeting of the House of Delegates will be held Thursday, April 13, at 3:30 p.m. in the Princess Martha Hotel. Delegates are requested to register as soon after arrival as possible. The registration desk will be located at the back of the technical exhibit hall.

Special badges have been prepared for delegates. To secure a delegate's badge, official credentials signed by the secretary of his county medical society must be presented by the delegate at the registration desk.

Delegates are requested to use the front section of the assembly room, and visitors the rear section, in order that official delegates may sit together as provided in the By-laws.

Chairmen of standing committees are urged to be present on time so their reports may be read as scheduled in the official program. All committee reports and resolutions are to be prepared in duplicate and both copies laid on the speaker's table immediately after reading.

Delegates and committee chairmen, please note the time and date of the first meeting of the House of Delegates—3:30 p.m., Thursday, April 13, Princess Martha Hotel.

**HELP EVALUATE INTENSIVE METHODS OF TREATING SYPHILIS**

Many physicians throughout the country are interested in the newer forms of treatment for syphilis, and numerous articles have been published on the so-called five day intensive method. A new form of treatment which has received wide publicity is the one day heat mapharsen method of treating early syphilis. Both of these methods are a departure from the old accepted standard technic. In the case of the five day drip method, some 5,000 patients have been treated by a midwestern group of physicians, who report that approximately 85 per cent of them have remained in a noninfectious state after five years of follow-up observation. A sufficient length of time has not elapsed to apply the same period of observation to the intensive one day heat mapharsen method of treatment. In Florida, however, this method has been used for almost two years, and approximately 1,000 patients have been treated. The form of treatment now employed indicates that about 90 per cent of the patients so treated will remain in a noninfectious

state and that this one day treatment so far has proved adequate.

All physicians in the state of Florida should familiarize themselves, or at least become acquainted, with these forms of therapy and are urged to do so by Dr. E. T. Sellers, chairman, Committee on Venereal Disease Control. It is vastly important that if in the immediate future we, as physicians, should adopt this therapy as a standard method of treatment, every means should be used now to help evaluate the method employed by the physicians who are engaged in this study. It must be remembered that in the patients treated by the intensive methods the reaction to the blood test will remain positive for some six or eight months. This positive reaction does not mean that the patient still has infectious syphilis. It has been found that the response to the blood test does not revert to a negative reaction until six or eight months after the intensive method of treatment has been given.

If we, as physicians, are to help evaluate this intensive form of therapy, we should by all means aid the physicians who are studying this method, so that we can adopt it as the accepted method of treating early infectious syphilis. It is, therefore, imperative that no additional treatment be given patients who have had an intensive form of therapy, because additional treatment will nullify the results anticipated from the intensive method. Since relatively few have relapses of the disease in infectious form, we are not increasing the health problem. If, however, a patient previously treated by the intensive method should have such a relapse, he should be returned to one of the Rapid Treatment Centers in the state for retreatment.

Every physician in the state who has occasion to interview a patient previously treated by one of the intensive methods should aid in the follow-up procedure recommended by the physician who rendered the intensive form of treatment. In order to determine whether a patient will have a relapse infectious in character, it is necessary to have a follow-up serologic test. By means of a quantitative serologic test, the physician can determine almost with certainty whether or not a relapse of this nature will occur. All physicians throughout the state are earnestly requested to assist in this all-important fight to eliminate syphilis from the state. It is the opinion of those who are dealing with this problem that the most effective way of eliminating this disease is by

use of the intensive method of treatment in all early infectious cases, for thereby the patient's condition is within a very short time rendered noninfectious, and the patient is eliminated as a potential source of infection.



## RELOCATED PHYSICIANS TEMPORARILY LICENSED

The following relocated physicians have been granted temporary licenses to practice medicine, each in a specified county in Florida, by the State Defense Council.

A certificate of need for such a physician must be filed by the county medical society or, in the absence of a county medical society, by the Board of Governors of the Florida Medical Association. These temporary licenses are subject to revocation by operation of law or by direction of the Governor, but in no event shall they continue in effect longer than six months after the end of World War II. Further information concerning the procedure may be found in the March, 1944 issue of the Florida Medical Journal.

NAME	T.L.	COUNTY
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F. L. Hall, M. D. ....	No. 3	Sarasota
G. Thomsen-von Colditz. ....	No. 4	Brevard
Mathew Mroz, M. D. ....	No. 5	Volusia
George Gartley, M. D. ....	No. 6	Orange
Binford Throne, M. D. ....	No. 7	Manatee
A. K. Swift, M. D. ....	No. 8	Clay
R. E. Balch, M. D. ....	No. 9	Brevard
T. W. Reed ....	No. 10	Escambia
Erwin F. Dudley, M. D. ....	No. 11	Okeechobee
H. E. Canfield, M. D. ....	No. 12	Monroe
Alexander Corpron, M. D. ....	No. 13	Clay

## BIRTHS AND DEATHS

### BIRTHS

Dr. and Mrs. R. P. Stritzinger of Pensacola announce the birth of a son, R. Peter, on February 17, 1944.

Dr. and Mrs. Ernest Bostelman of Fort Myers announce the birth of a daughter, Linda Carol, on February 3, 1944.

### DEATHS

Dr. William R. Warren of Key West died on February 14, 1944.

Dr. Millen A. Nickle of Clearwater died on March 6, 1944.

Dr. Lyman L. Bunker of Fernandina died on March 8, 1944.

## STATE NEWS ITEMS

A remittance of \$60 was received in March for six members in military service from the St. Lucie-Okeechobee-Indian River-Martin County Medical Society. This society by special action decided to pay 1944 dues for its six members with the armed services. This timely action by a county medical society is appreciated, owing to the fact that the State Association's income from state dues has been reduced about 30 per cent because of the war effort.



The U. S. Office of Civilian Defense on February 24 announced that its Chief Medical Officer, Dr. George Baehr, would retire on March 1, after two and a half years of service. He was succeeded by Dr. W. Palmer Dearing who has been assistant Chief Medical Officer since the establishment of the Medical Division of the Office of Civilian Defense.



Dr. W. M. Goodson of Miami announces that Dr. William Redman has become associated with him. Their office is located at 1100 N.E. First Ave.

## COMPONENT COUNTY SOCIETIES

## ALACHUA

At the annual meeting of the Alachua County Medical Society, the following officers were elected: president, Dr. Walter E. Murphree; vice president, Dr. Wilburn Lassiter, and secretary-treasurer, Dr. John H. Thomas, all of Gainesville.

## BREVARD

The following officers have been elected by the Brevard County Medical Society, to serve during 1944: president, Dr. I. F. Bean, Melbourne; vice president, Dr. A. F. Thomas, Cocoa, and secretary-treasurer, Dr. I. K. Hicks, Melbourne.

## BROWARD

Dr. John A. Johnston of Ft. Lauderdale is the new president of the Broward County Medical Society; Dr. O. C. Brown of Ft. Lauderdale is continuing to serve as secretary-treasurer.

## FRANKLIN-GULF

The Franklin-Gulf County Medical Society has paid 100% of its membership dues for 1944. Officers of this society are: president, Dr. Thomas A. Meriwether, Wewahitchka; vice president, Dr. L. H. Bartee, Port St. Joe, and secretary-treasurer, Dr. J. R. Norton, Port St. Joe.

## JACKSON

At a meeting of the Jackson County Medical Society held on February 15 at the Jackson Hospital, Marianna, Dr. Courtland D. Whitaker of Marianna was elected president. Dr. R. L. Miller of Graceville was named vice president and Dr. C. A. Adams, Jr. of Marianna was elected secretary-treasurer.

## PASCO-HERNANDO-CITRUS

The regular meeting of this society was held at Magnolia Lodge, Crystal River, Thursday evening, February 10. Interesting clinical cases were reported by Drs. S. C. Harvard, P. J. Hudson, W. H. Walters and W. Wardlaw Jones, followed by a general discussion. At the business session Dr. S. C. Harvard was elected delegate to the meeting of the House of Delegates of the Florida Medical Association; Dr. W. Wardlaw Jones was elected alternate. Official action was taken to accept the Farm Security Administration's Health Plan for 1944. Dr. P. J. Hudson entertained those present with a full course fish and oyster dinner. A hearty vote of appreciation was voted Dr. Hudson for his hospitality and entertainment. Members present were Drs. G. R. Creekmore, P. J. Hudson, S. C. Harvard, W. Wardlaw Jones, W. B. Moon and W. H. Walters. Dr. J. L. Estes of Tampa was a guest at this meeting.

## PINELLAS

Lt. Comdr. Leo D. O'Kane and his staff of the maritime training station at St. Petersburg were in charge of an interesting program given for the members of the Pinellas County Medical Society at a dinner meeting held on the evening of February 4.

On February 18 the members of this society held a round table assembly at the home of Dr. W. E. Quicksall, at which time the topic for discussion was "The Common Cold." Dr. Quicksall acted as moderator.

This society is to be congratulated on having its membership dues 100% paid for 1944. At present it is the largest fully-paid society in the Association.



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## POLK

Dr. Henry Hanson, State Health Officer, was guest speaker at a meeting of the Polk County Medical Society held at the County Hospital, Bartow, on Wednesday evening, February 9. He spoke on phases of public health work. A clinical program was presented later by Drs. W. F. Peacock and E. E. Sawyer of the hospital staff.

## PUTNAM

The Putnam County Medical Society is on the Honor Roll of 100% paid societies. Officers of this organization are: president, Dr. Bernard E. Kane; secretary-treasurer, Dr. E. W. Ford, both of Crescent City.

## ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN

At a special called meeting of this society, held in Ft. Pierce on March 2, the following officers were elected: president, Dr. M. D. Council; vice president, Dr. L. L. Whiddon; secretary-treasurer, Dr. A. M. Sample, and censor, Dr. F. A. Gowdy.

It was moved, seconded and carried that the society pay the state dues of its members in the armed services.

## SEMINOLE

The regular meeting of the society was held February 8. The question of the local doctors equipping the new operating room of the Fernald-Laughton Memorial Hospital was discussed at length. The president was instructed to appoint a committee to contact the individual physicians and ascertain how many would be willing to donate for the equipment. He appointed Dr. Wade H. Garner as a committee of one to make the necessary investigation and report back at the next meeting. Members present were Drs. Leland H. Dame, Wade H. Garner, W. T. Langley, Samuel Puleston, J. N. Robson and J. A. Smith.

## TAYLOR

The Taylor County Medical Society has paid 100% of its membership dues for 1944. Officers of this society are: president, Dr. W. J. Baker; vice president, Dr. R. J. Greene, and secretary-treasurer, Dr. C. A. O'Quinn.

## WASHINGTON-HOLMES

The Washington-Holmes County Medical Society has paid 100% of its membership dues for 1944. Officers of this society are: president, Dr. N. J. Dawkins; secretary-treasurer, Dr. B. W. Dalton, both of Vernon.



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## THE TECHNICAL EXHIBIT

The firms hereinafter listed will contribute materially to the success of the convention. Make it a point to visit each booth some time during the annual meeting.

### BILHUBER-KNOLL CORP.

Visit the exhibit at Booth No. 23 for the latest information on the uses of such Council-accepted medicinal chemicals as Theocalcin in rheumatic heart diseases and Metrazol in heart block. Mr. Harry O. Burks will be on hand to welcome your discussions on these every-day prescription chemicals.

### THE BORDEN CO.

You will receive a cordial welcome at the Borden Booth No. 27. There on display will be a line of scientific infant formula foods which the company's representative will be pleased to discuss with you—Biolac, New Improved Dryco, Mull-Soy, Klim, Beta Lactose, and Merrell-Soule Powdered Milks.

### CAMEL CIGARETTES

Camel Cigarettes will exhibit large detailed photographs of equipment used in comparative tests of the five largest selling brands of cigarettes. Dramatic visualization of nicotine absorption in the human respiratory tract from cigarette smoke will be demonstrated.

### S. H. CAMP & COMPANY

S. H. Camp & Company, Jackson, Michigan, will use a series of anatomic drawings by Tom Jones as the central theme of their exhibit. A complete line of anatomic supports for prenatal, postnatal, postoperative, orthopedic, visceroptosis and hernial conditions will be shown. Experts from the Camp staff will be in attendance to answer questions.

### THE COCA-COLA COMPANY

Coca-Cola will be served members and their guests with the compliments of The Coca-Cola Company.

### ENDO PRODUCTS, INC.

During the past year Endo Products, Inc., passed the One Hundred Million mark in the manufacture of ampuls. This fact was noted in their advertisement of September 25, 1943 in the J.A.M.A. The recent acquisition of another building facilitates still greater increase in their ampul production.

### EVERHART SURGICAL SUPPLY CO.

The Everhart Surgical Supply Co. will have a complete display at Booth No. 31. Mr. G. I. Butzer will be there to greet you. This firm's headquarters is at 493 Peachtree Street, Atlanta, Ga.

### C. B. FLEET COMPANY, INC.

The exhibit in Booth No. 28 will feature Phospho-Soda (Fleet), which has been an ethical product for over half a century. This is a pure, stable, aqueous concentrate of the two U.S.P. sodium phosphates. It is indicated in hepatic and gallbladder dysfunction and whenever a thorough eliminating action is desired. It possesses rapidity and mildness of action, with marked absence of nausea, griping or tenesmus.

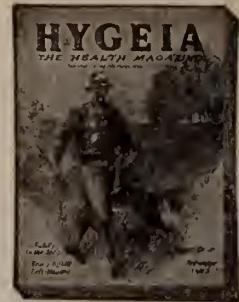
### JONES METABOLISM EQUIPMENT CO.

Mr. Jim Merrihew, Factory Representative, will have on display and demonstrate the Jones Motor Basal Metabolism machine.

## HYGEIA

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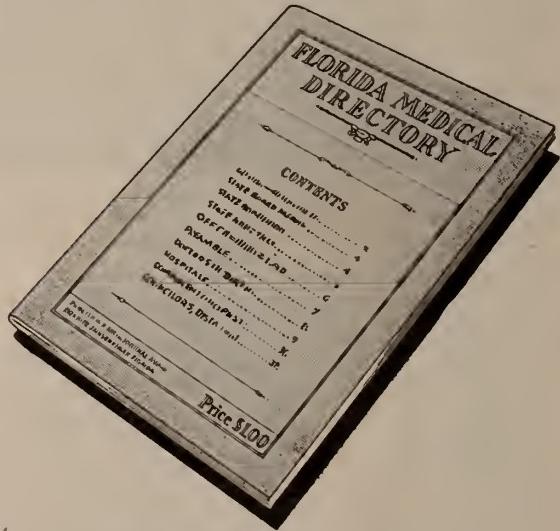
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## KELEKET X-RAY CO.

The Keleket X-Ray Co. of Florida extends to all members of the Association, and especially to their good friends and customers, an invitation to visit Booth No. 24 during the convention. Representatives of the company welcome the opportunity again to meet friends on whom they have not been able to call for a considerable time. The reason they have been unable to make personal calls is that the company has installed in the State of Florida, and has to maintain, 23 X-Ray installations in Army and Navy camps. This is in addition to the regular maintenance of civilian X-Ray, Electro-Surgical, Short Wave and Electrocardiograph equipment. Since three men have been lost to the armed services, it is understandable that good-will calls have not been made.

## LEDERLE LABORATORIES, INC.

Lederle Laboratories, Inc., of New York, whose exhibit will be No. 6, will display a number of their more important specialties of interest to all physicians. These specialties will include Biologic, Vitamin, and Pharmaceutical items. A visit to this exhibit will find those in charge eager and anxious to discuss their products of merit.

## ELI LILLY AND COMPANY

The Lilly exhibit will feature an anatomic model illustrating the technics of caudal and spinal anesthesia. Lilly products will be on display, and medical service representatives will be present to assist visiting physicians in every possible way.

## M. &amp; R. DIETETIC LABORATORIES, INC.

M. & R. Dietetic Laboratories, Booth No. 20, will display Similac, a food for infants deprived partially or entirely of breast milk; also powdered SofKurd. Mr. E. E. Rader will appreciate the opportunity to discuss the merit and suggested application of these products for both the normal and special feeding case.

## THE MALTINE COMPANY

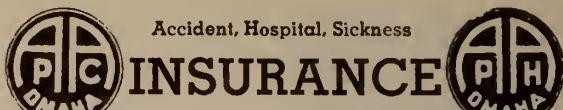
The Maltine Company, New York, will have on display in Booth No. 15 many of the products for which they have been known since 1875—Maltine with Cod Liver Oil, Maltine Plain, and Malto-Yerbine. Also displayed will be newer products which are the result of the latest research undertaken at their Research Laboratories, particularly Proloid, Tedral, and Depancol.

## MEAD JOHNSON &amp; COMPANY

"Servamus Fidem" means We are Keeping the Faith. Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum and other infant diet materials—including the new precooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booth No. 14 will be time well spent.

## THE WM. S. MERRELL COMPANY

Particular attention is called to a new development of Merrell Research for local treatment of pyogenic infections—Sulfa-Ceepyn Cream, which employs the unique detergent-germicide, Ceepyn, to reinforce the balanced bacteriostatic action of sulfathiazole and sulfanilamide. Other Merrell prescription specialties of established usefulness in clinical medicine will also be displayed at Booth No. 19.



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\$5,000.00 accidental death	\$32.00
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**MEDICINE**—Two Weeks Intensive Course Internal Medicine starts June 19. Two Weeks Course Gastro-Enterology starts June 5.

**GYNECOLOGY**—Two Weeks Intensive Course starting June 12. One Week Personal Course Vaginal Approach to Pelvic Surgery starts April 17.

**OBSTETRICS**—Two Weeks Intensive Course starts April 17 and June 26.

**ANESTHESIA**—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

**GASTROSCOPY**—Personal Course starts April 3, June 19, and October 16.

**OTOLARYNGOLOGY**—Two Weeks Intensive Course starts April 3 and October 2.

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A complete display of material illustrating the time-saving Pet Milk services available to physicians will be shown in Booth No. 18. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

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## SHARP &amp; DOHME

Sharp & Dohme will have their display at Booth No. 12, featuring their new sulfonamide, Sulfamerazine, and also 'Sulfasuxidine,' 'Lyovac' Normal Human Plasma, Tyrothricin Concentrate (Human), 'Depropanex,' 'Delvinal' Sodium, 'Propadrine' Hydrochloride products and 'Lyovac' Tetanus Antitoxin, Bovine. Capable, well informed representatives will be on hand to welcome all visitors and furnish information on Sharpe & Dohme products.

## SOUTHEASTERN OPTICAL CO.

The Southeastern Optical Co., Inc., an affiliate of the Bausch & Lomb Optical Company, distributes and services the instruments and equipment made by Bausch & Lomb for Ophthalmologists. Under the present conditions, the line is limited because of the great demands made by the Army and Navy but many items are still available.

## SPENCER INCORPORATED

Spencer Incorporated will have an interesting exhibit at Booth No. 17, featuring individually designed supports for abdomen, back and breasts. Spencer Supports are prescribed as an aid to treatment for the following: Hernia—Visceroptosis with symptoms—Postoperative—Back Conditions—Maternity and Postpartum—Obesity—Movable Kidney—Breast Conditions and certain forms of Heart Disease. Samples will be displayed and trained representatives will be available to answer your questions.

## E. R. SQUIBB &amp; SONS

Physicians attending the Florida Medical Association Meeting are cordially invited to visit the Squibb Exhibit, Booth No. 25. Several new items will be shown. Among them are Intocostrin, the standardized Purified Curare Extract now widely used to soften convulsion in shock therapy; a new, highly useful therapeutic multi-vitamin preparation; a sulfathiazole-ephedrine-derivative combination for ophthalmic use.



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## SURGICAL SUPPLY COMPANY

The Surgical Supply Company of Jacksonville, Tampa, Miami and Orlando will occupy Booth No. 7, in which they will show a modern Ear, Nose and Throat Treatment Chair and Unit.

## TABLEROCK LABORATORIES

The Tablerock Laboratories thank the doctors for the very kind consideration given to their products. Be it war or peace, their constant endeavor will be to make and market products that harmonize with the ethics and high standards of the medical profession. Harry Brown, Florida Representative.

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The Tower Company, Inc., manufacturing and research specialists in fracture equipment, invites you to look over the new Roger Anderson Self-Aligning Fracture Reduction Splint with the free-floating traction control. This ingenious device allows the bone fragments to move into alignment when traction is properly applied. Other items of particular interest to the orthopedic surgeon are the Universal Frac-Sure Units for skeletal fixation of every type of fracture including fractures of the mandible, new model Clavicle Splints, Steinmann Pin and Kirschner Wire Drill, and additional standard fracture equipment.

## WALKER VITAMIN PRODUCTS, INC.

An extensive line of ethical vitamin products will be exhibited at Booth No. 2. Featured products will be the Council-Accepted A-D Drops and Straight Vitamin Tablets. Also of special interest is the new super potency B Complex product Neobevin and the high potency Mineralized Vitamin Tablets. This new Multi-vitamin-mineral product is fat free and without any fishy after taste. Samples will be available.

## WHITE LABORATORIES

At the White Laboratories' Booth No. 30 you will find interesting copies of a series of publications under the general title "Diagnostic Aids to Vitamin Deficiency Conditions." Medical Service Representatives in attendance will be glad to discuss these with you. The latest clinical reports on results of the use of White's Vitamin A and D Ointment in the treatment of burns and various types of ulcers will also be available. This is a product which you will undoubtedly find of great interest.

## WYETH INCORPORATED

Wyeth Incorporated invite you cordially to visit their booths which will feature the medical specialties of their nutritional, biologic and pharmaceutical divisions.

## ZIMMER MANUFACTURING CO.

J. F. Hartle of the Zimmer Manufacturing Company of Warsaw, Indiana, will be in Booth No. 22 to demonstrate and exhibit a complete line of splints and bone instruments, featuring the Reduction-Retention Apparatus for external skeletal fixation, and the Stryker Screw Driver, which holds screws with complete rigidity.

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Most civilian physicians are working too hard for comfort, in many instances literally "rushed to death." After all, the average age of doctors on the home front must be well up in the fifties.

They would be serving their country and their families better—and longer—by taking a little time out to follow an artistic hobby such as sketching, photographing, water coloring, painting, even whittling.

Art may be easier to take than exercise, yet affords you respite from strain and worry, at the same time offering limitless opportunities for self-expression and the joy of achievement!

Now is a good time to get ready to exhibit your artistic handicraft at the annual exhibition of the American Physicians' Art Association which will be held with the A.M.A. Session, June 12-16, 1944 in the gallery of the beautiful Grand Ballroom, Stevens Hotel, Chicago.

You can get full particulars by writing to the Secretary, Dr. F. H. Redewill, Flood Bldg., San Francisco, Calif.

Regardless of how long you've "dabbled in art," you can win a prize—and lighten the war's burden on your heart and arteries.



## NEW TEST FOR GROUND GLASS SURFACES

A new and simple method of testing the accuracy of ground optical surfaces by means of optical test glasses has recently been adopted at the Bausch & Lomb Optical Co. It employs wax to fill up the matrix of furrows created by emery in the grinding process.

A ground surface is such a poor reflector of light that the usual method of examining polished surfaces by means of the light interference pattern is not practicable. When the rough surface is given a smooth coating of wax it becomes reflecting and its accuracy may be measured with a test glass having the proper curve or degree of planeness. This method is valuable in saving time and labor in the polishing process which follows grinding. The previous method of testing, by an optical spherometer, afforded less than one-tenth the accuracy attainable with test glasses.

The test glass, employed with monochromatic light, is the most accurate method known for discovering the nature and amount of surface irregularities. Utilizing light waves, which are fundamental and unalterable units of measurement, test glasses disclose, by the phenomena of interference, a series of bands or rings created by light reflected from the surface of the measured object and the test glass. The arrangement of these bands in parallel patterns or concentric rings shows the nature and amount of irregularity in fractions of a millionth of an inch.



## LIGHT TRANSMISSION OF BINOCULARS INCREASED

A 35 per cent increase in the light transmission of binoculars, which enables an observer to see distant targets better in dim light with clearer definition, is made possible by a new method of removing light reflections from glass, H. R. Moulton, asst. research director of the American Optical Company, announced recently.

Approximately 55 per cent of light is transmitted by a binocular lens system, he said, most of the remaining light being lost through reflections. However, by subjecting the lenses to the new technique of saving lost light, a gain of over 35 per cent in light transmission results, he declared.

The discovery making this possible consists of a new surfacing treatment which for the first time reduces re-

flections on large areas of glass, glossy paper, oil paintings and varnished wood. Previous methods of removing reflected light were limited to glass and were practical for small pieces only.

The new reflection remover is a military secret and its composition, method of application, and military uses cannot be revealed at the present time.

The discovery's postwar applications include the removal of annoying or dangerous light reflections from auto windshields, eyeglasses, shop windows and cases, clock faces, paintings, photographs, and camera and instrument lenses.

## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

PSYCHOSOMATIC MEDICINE. *The Clinical Application of Psychopathology to General Medical Problems.* By Edward Weiss, M. D., Professor of Clinical Medicine, Temple University Medical School, and O. Spurgeon English, M. D., Professor of Psychiatry, Temple University Medical School, Philadelphia. This book deals with a field of immense public importance, as well as of interest. The type of disorder discussed, intimately bound up with obscure factors, is a heavy contributor to the cost of medical care, especially when it is not understood, and is the basis of much criticism of medical service. The book is so constructed that the busy practitioner can read the first two chapters and the last four and get a general idea of the subject. Cloth. Pp. 687. Philadelphia: W. B. Saunders Company, 1943.



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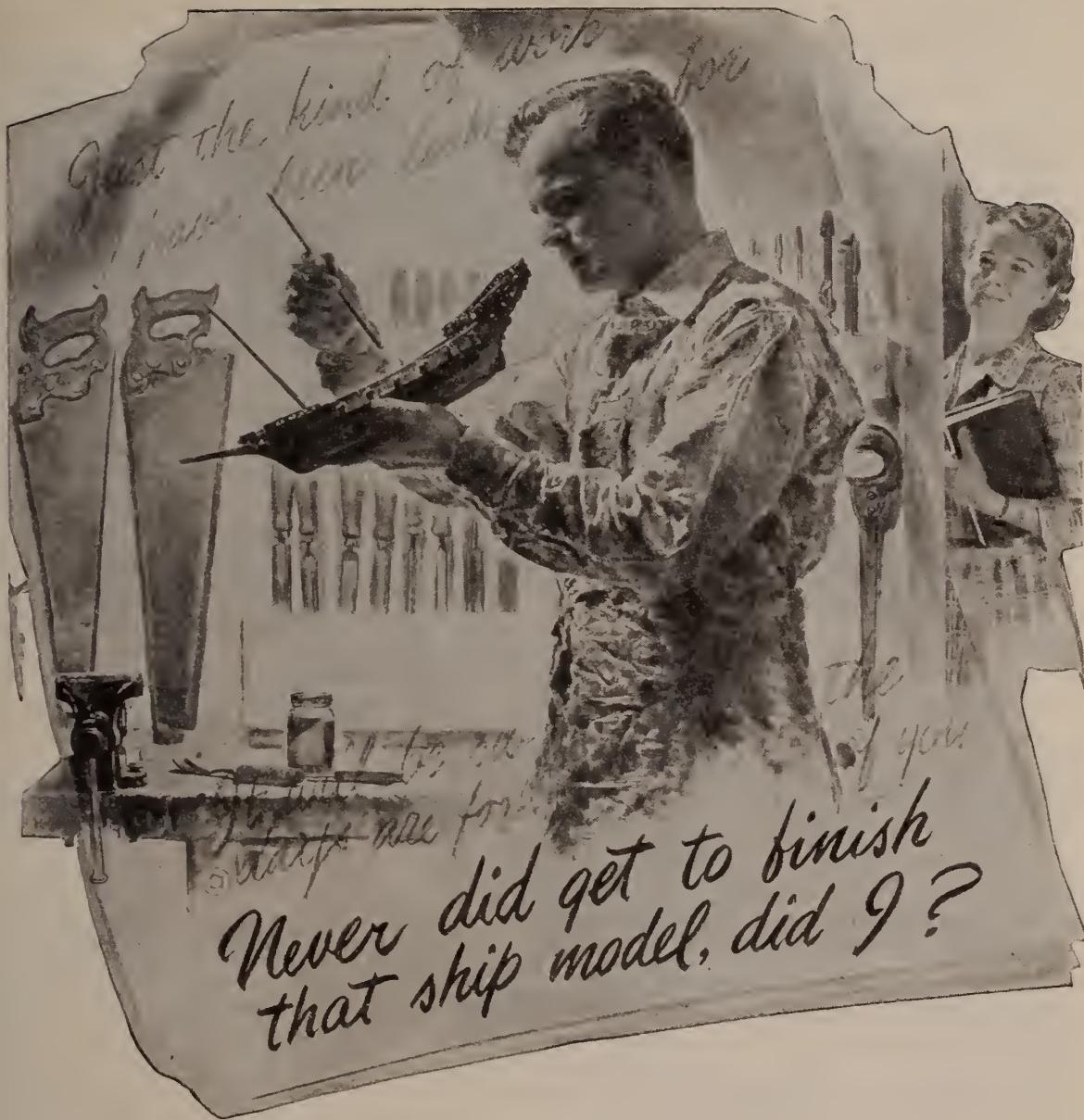
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Funny, how it's the *little* things he always writes about so far from home . . . the little things that seem important to him . . .

"Is Johnny keeping my tools in shape . . . Do they still pitch horseshoes back of Kelley's . . . How are the strawberries coming up? . . . Sure miss those picnics we had with Mary at Birch Grove" . . .

But maybe it's not so funny when you stop to think of it. For after all, isn't it the little things that

help mean home to all of us?

It happens that to many of us these important little things include the right to enjoy a refreshing glass of beer or ale . . . as a beverage of moderation after a day's work . . . with good friends . . . with a home-cooked meal.

A glass of beer—not of crucial importance, surely . . . yet it is little things like this that help mean home to all of us, that do so much to build morale—ours and his.



Men of the United States Marine Corps say letters keep up morale . . . Write that V-Mail letter today.

## Morale is a lot of little things (As you, Doctor, know better than most)



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**ANNUAL CONVENTION**

Dear Friends and Co-Workers:

This will be my last Journal message to you as your state president. How quickly the time passes. Another year of war and unrest is behind us. I am looking forward to seeing many of you at the coming state meeting in April, but due to unfavorable traveling conditions, many will not attend. I therefore take this opportunity to express my sincere thanks to all my board members and chairmen for their loyalty and co-operation during the past year, and to all other members who have faithfully carried on the work of our organization. Most especially do I wish to express my thanks to our Press and Publicity chairman, Mrs. S. M. Copeland, for her efficient and untiring work during the past months. She has been my right arm at all times, and words cannot express my real gratitude.

My one regret during my term in office has been that I could not travel and make new contacts, and renew old ones, as I had so much hoped to do. In spite of all our difficulties, we have held together the largest number of our auxiliaries. Much has been accomplished along lines of defense work and social entertainment. Just how much we have responded to the various calls for aid will be revealed when annual reports are given at the state meeting.

Our annual meeting will be held at St. Petersburg on April 13 and 14. Headquarters are to be at the Princess Martha Hotel. Our Auxili-

ary meetings will be held at the Army and Navy Club. The preconvention Board meeting will begin at 9 a.m. on the 14th, the general business meeting at 9:30 a.m., and lunch will be served at 1 p.m. Since traveling conditions are so difficult, travel lightly. Come with the will to make this meeting worth while for yourself and others. As in all things, let us think of conservation and efficiency as we go to this state meeting of 1944.

Our national convention will convene in Chicago this year, June 12-16. Keep this date in mind and make plans to go it at all possible. Details on this meeting will appear later.

It has been a privilege and a pleasure to serve as your state president. With greetings and best wishes for the continued success of our Auxiliary, I bid you farewell.

LYDIA KRUEGER (MRS. F. W.)

**THE ANNUAL CONVENTION**

**PROGRAM—PAGE 433**

**CONVENTION PRESS**

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## SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Eugene G. Peek, Ocala.....	Shaler Richardson, Jacksonville.....	St. Petersburg, Apr. 13-14, 1944
Florida Medical Districts:			
—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
—Northeast .....	L. Y. Dyrenforth, Jacksonville....	" " "	Ocala, Postponed
—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
—Southeast .....	William Y. Sayad, W. Palm Beach.....	" " "	Miami, Postponed
American Medical Association.....	James E. Paullin, Atlanta, Ga.....	Olin West, Chicago.....	Chicago, June 12-16, 1944
Florida Medical Association.....	W. T. Wootton, Hot Spgs., Ark.....	Mr. C. P. Loranz, Birmingham.....	November, 1944
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	Montgomery, Apr. 18-20, 1944
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	Savannah, May 9-12, 1944
Florida—			
Florida, Am. College Phys.....	R. H. Knowlton, St. Petersburg....	Kenneth Phillips, Miami.....	St. Petersburg, April 13, 1944
Florida Science Exam. Board .....	M. W. Emmel, D.V.M., Gainesville	J. F. Conn, Ph.D., DeLand.....	Gainesville, June 8, 1944
Florida Dental Society, State.....	E. C. Lunsford, D.D.S., Miami.....	H. L. Cartee, D.D.S., Miami.....	St. Petersburg, April 13, 1944
Florida Derm. and Syph., Soc. of.....	Wiley M. Sams, Miami.....	Lauren M. Sompayrac, Jacksonville	Postponed
Florida East Coast Medical Association.....	T. C. Kenaston, Cocoa.....	I. M. Hay, Melbourne.....	St. Petersburg, April 13, 1944
Florida Hospital Association.....	Mr. W. E. Arnold, Jacksonville.....	Miss Katharine Moyer, Lake Wales...	Jacksonville, June 26, 27, 1944
Florida Industrial Surgeons, Assn. of.....	Frank D. Gray, Orlando.....	A. M. Bidwell, Tampa.....	
Florida Medical Examining Board .....	George S. McClellan, Pompano.....	W. M. Rowlett, Tampa.....	
Florida Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville.....	Chairman	
Florida Nurses Association, State.....	Miss Florence Jones, Jacksonville	Miss Madalee Hazel, Limona.....	
Florida Ophthal. & Otol., Soc. of.....	Shaler Richardson, Jacksonville....	C. E. Dunaway, Miami.....	
Florida Pathological Society.....	L. Y. Dyrenforth, Jacksonville....	Iva C. Youmans, Miami.....	
Florida Pediatric Society.....	Ludo von Meysenbug, Daytona B.	Robert Blessing, Ft. Lauderdale....	
Florida Pharmaceutical Association, State.....	Mr. H. B. Douglas, Bonifay.....	Mr. R. Q. Richards, Ft. Myers.....	
Florida Public Health Association.....	Leland H. Dame, Sanford.....	E. M. L'Engle, Jacksonville.....	
Florida Radiological Society .....	John N. Moore, Ocala.....	Walter A. Weed, Orlando.....	
Florida Railway Surgeons' Association.....	Frank D. Gray, Orlando.....	W. C. Page, Cocoa.....	
Florida Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales.....	Mrs. May Pynchon, Jacksonville	
Florida Attahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine.....	Robert B. McIver, Jacksonville.....	
Florida Gulf Coast Clinical Society.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	
Florida Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola.....	Kenneth Phillips, Miami.....	
Florida Eastern Surgical Congress.....	Alton Ochsner, New Orleans.....	B. T. Beasley, Atlanta.....	
Florida Panhandle River Medical Society.....	L. J. Arnold, Jr., Lake City.....	H. S. Howell, Lake City.....	

# S I M P L I C I T Y

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**COMPONENT SOCIETIES BY MEDICAL DISTRICTS**

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Don S. Fraser, M.D. 456 Grace Ave. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		14	100%	
Escambia *Santa Rosa	J. K. Turberville, M.D. Century	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	47	42	C. D. Whitaker, M.D. Marianna
Franklin-Gulf	T. A. Meriwether M.D. Wewahitchka	J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	6	100%	A-1-45
Jackson *Calhoun	C. D. Whitaker, M.D. Burton Bld., Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	1	
Walton-Okalooza	E. L. Huggins, M.D. DeFuniak Springs	A. G. Williams, M.D. Lakewood	3rd Thursday 8:00 P.M.	6	100%	
A Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	100%	
Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	John L. Williams, M.D. Tallahassee	L. L. Dozier, M.D. Midyette-Moor Bldg. Tallahassee	Quarterly 8:00 P.M.	40	34	A-2-44 William D. Rogers, M.D. Chattahoochee
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		9	100%	
Taylor *Dirie, Lafayette	W. J. Baker, M.D. Foley	C. A. O'Quinn Perry	Last Friday 8:00 P.M.	4	100%	
Alachua *Bradford, Gilchrist, Union	W. E. Murphree, M.D. 12/0 Seminole Ave. Gainesville	J. H. Thomas, M.D. 449 E. Main St. N. Gainesville	2nd Wednesday 7:30 P.M.	27	24	
Duval *Clay	J. G. Lyerly, M.D. 514 Greenleaf Bldg. Jacksonville 2	O. E. Harrell, M.D. 712 Laura St. Jacksonville 2	1st Tuesday 8:15 P.M.	193	176	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
Marion *Levy	Robbins Nettles, M.D. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	26	23	
Nassau	W. A. Brewster, M.D. Callahan	Geo. A. Dame, M.D. Fernandina	2nd Wednesday 8:00 P.M.	7	6	
Putnam	Bernard E. Kane, M.D. Crescent City	E. W. Ford, M.D. Crescent City	2nd Tuesday Even Months 7:00 P.M.	9	100%	
St. Johns	G. Walter Potter, M.D. East Coast Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	I. F. Bean, M.D. Melbourne	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	9	
Lake *Sumter	H. S. Cherry, M.D. Center Hill	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	17	B. 4-44 D. T. McEwan, M.D. Orlando
Orange *Osceola	Duncan McEwan, M.D. 106 E. Central Ave. Orlando	Albert C. Kirk, M.D. 823 E. Colonial Dr. Orlando	3rd Wednesday 8:00 P.M.	95	90	
Seminole	Samuel Puleston, M.D. Brumley-Puleston Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	13	5	
Volusia *Flagler	T. H. Dillard, M.D. DeLand	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	43	30	
Hillsborough	R. S. Torbett, M.D. 814 First Nat. Bk. Bldg. Tampa 2	Charles M. Gray, M.D. 306 Citizens Bldg. Tampa 2	1st Tuesday 8:00 P.M.	104	91	
Manatee	S. G. Hollingsworth, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	14	12	C-5-44 Leland F. Carlton, M.D. Tampa
Pasco-Hernando- Citrus	S. C. Harvard, M.D. Brooksville	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	II	100%	
Pinellas	J. A. Hardenbergh, M.D. 404 Power & Light Bldg. St. Petersburg 5	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg 4	1st and 3rd Fridays 6:30 P.M.	107	100%	
C Sarasota	O. H. Cribbins, M.D. 138 N. Link Sarasota	J. E. Harris, M.D. 224 Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	18	100%	
DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	100%	
Lee *Collier, Hendry	M. F. Johnson, M.D. Box 1266 Fort Myers	W. A. Harrison, M.D. 1029 First St. Fort Myers	3rd Tuesday 7:30 P.M.	17	100%	C-6-45 Edgar Watson, M.D. Lakeland
Polk	W. F. Peacock, M.D. Barnett Embry Bldg. Bartow	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	62	15	
Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	E. W. Stephens, M.D. 910 Harvey Bldg. W. Palm Beach	4th Monday 8:00 P.M.	64	53	D-7-45 William Y. Sayad, M.D. West Palm Beach
St. Lucie- Okeechobee-Indian River-Martin	M. D. Council, M.D. Box 607 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	13	
Broward	J. A. Johnston, M.D. 222½ S. Andrews Ave. Ft. Lauderdale	O. C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	2nd Tuesday 8:00 P.M.	41	39	D-8-44
Dade	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami, 32	J. J. Nugent, M.D. 701 Huntington Bldg. Miami, 32	1st Tuesday 8:30 P.M.	350	266	Elbert McLaury, M.D. Hollywood
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West		1st Sunday 9:00 P.M.	5	2	

\*Supervise and aid until organized separately.

# Missing...



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Mom says you must be brave. "It's what your father would expect of us," she tells you when it's bedtime and your chin starts to feel shaky. Then she kisses you extra hard and turns her head away so you can't see her eyes.

You've never let her see you cry. Not once, since that telegram came and she twisted it all up in a ball, then smoothed it and put it in the desk.

But, lying in bed, you play "Pretend" — pretend you can hear his step as he comes up to your room — pretend you can feel a stubble brush your forehead. And sometimes, in the dark, you can almost smell a cigarette-y suit close to your face.

Later you dream — dreams that you don't tell about. And in the morning you wake up with that funny, empty feeling in your stomach.

\* \* \*

Poor little guy. We — all of us — wish there were something we could do. Perhaps there is. Why shouldn't it be this?

We can resolve that the plans your father had for you shall remain within your reach, that you shall have the chance to grow and learn, that your opportunities will be bounded only by your own get-up-and-go, that you will progress and prosper in direct relation to your own ability — in a land of freedom and opportunity.

Those are the things your Dad valued, the things for which he gave his life. Though some may strive to change all that — provide you with the "benefits" of an all-powerful government, the "advantages" of regimentation, the "blessings" of bureaucracy — we can resolve they won't succeed.

\* \* \*

You, son, won't read these words, and if you did, they wouldn't mean much to you now. But your father's friends — known and unknown — are making you a promise, just the same.

You may never hear it from their lips. But if you were older you would read it in their faces — recognize it in their spirit. They are determined to keep America free. To keep it a land in which government is the servant, not the master of the people. To keep it the kind of America your Dad wanted to preserve — for you.

MAY 15 1944

P R Y

# The JOURNAL *of the* Florida Medical Association, Inc.

Vol. XXX

MAY, 1944

No. 11

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## The Journal of the Florida Medical Association

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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## RIEDEL'S STRUMA

HERBERT R. MILLS, M.D.

AND

HOMER H. WHITNEY, M.D.

TAMPA

In 1896, Riedel<sup>1</sup> described a form of chronic inflammation of the thyroid gland of unknown origin, which transformed the organ into a bulky tumor, composed of dense fibrous and sclerotic tissue, and which involved the entire gland. This peculiar and uncommon condition has been variously called woody thyroiditis, iron hard tumor, lymphadenoid goiter and dense fibrosis of the thyroid.

The entire gland is usually involved, but the involvement may be limited to one lobe. The enlargement usually takes place rather quickly, and with notable uniformity. Potassium iodide is without effect. In cases observed for years, there have been no cachexia, no involvement of neighboring glands and no metastasis. The disease was originally diagnosed as syphilis of the thyroid. It has also been confused clinically with carcinoma, and microscopically with tuberculosis. Cut sections of the thyroid appear of a grayish or whitish color, or even a faint pink. The feel of the extirpated gland is that of a peculiar hard resiliency.

In the microscopic picture there is great infiltration with lymphocytes and lymph follicles. The lymph follicles are later replaced by dense scar tissue. There is a considerable degree of destruction and degeneration of the parenchyma. Epithelial cells fuse around areas of colloid, making pseudo giant cells which strangely resemble those of tuberculosis. The lymphoplasmia may also resemble carcinoma of the thyroid. In early stages microscopic sections show numerous lymph follicles in the gland with reticular cells so numerous as to suggest lymphosarcoma. The persisting reticular cells incarcerated between the hyaline strands of fibrous tissue may resemble a small cell alveolar carcinoma. All stages of atrophy of alveolar epithelium can be traced, also many stages of fibrosis and hyaline degeneration, causing the gland to become enlarged and hard. Thus it would seem that there is an early stage in

which the chief symptom may be toxicosis, merging into an intermediate stage and later a final or fibrous stage.

In 4 cases reported by Ewing,<sup>2</sup> there was an apparent transition of a lymphoid goiter to the fibrous process seen in Riedel's struma. In these cases there was a particularly active growth of the thyroid gland for a few months, which later became stationary in size. Various authors have described conditions that they considered different types of Riedel's struma, but which may be different stages of one disease. McCarrison and Madhava<sup>3</sup> produced in rats a condition simulating Riedel's struma by causing deficiency of vitamins A, C and D, with the goiter appearing as early as the seventy-fifth day in 25 per cent of the cases. This condition was noticed more frequently in female rats, and the glands became five times the normal size. German<sup>4</sup> suggested that Riedel's struma is a degenerative disease comparable to cirrhosis of the liver or nephrosclerosis. The arteriolar sclerosis and the interpretation of the so-called giant cells presented by Goetsch<sup>5</sup> are in accord with this view.

Clinically, Riedel's struma is characterized by a rapid enlargement of the thyroid gland for a period averaging seven months and is usually observed in adults of middle age. It happens with equal frequency in the sexes and may occur at any age. There is practically always a feeling of tightness in the neck, or back, or shoulders, with much local pain. Drawing pains along the neck have been described. There is also tenderness in the tumor itself, with dysphagia, severe dyspnea, cough, hoarseness and tracheal displacement. The feel of the tumor is firm, resistant and fixed. There is no exophthalmos.

The white blood cell count ranges from 10,000 to 15,000. The basal metabolic rate averaged +20 per cent in one case reported, but usually it is normal. There is no response to Lugol's solution, and the chronic inflammatory or granulomatous condition may progress to myxedema with a remarkable degree of destruction of the thyroid, or the progress may be arrested at any time.

There is often great benefit by even a partial resection of the gland as it appears to relieve the pressure on the remaining thyroid, causing recession of the process. The gland has



Fig. 1. Riedel's struma with giant cell formation. Granuloma-like lesion with centrally disposed giant cells. Also dense fibrosis at one end of the section. Hematoxylin and eosin X 142.



Fig. 2. Riedel's struma with giant cell formation. Cluster of giant cells, one of which contains in its cytoplasm a circular mass of acidophilic hyaline material. Hematoxylin and eosin X 142.

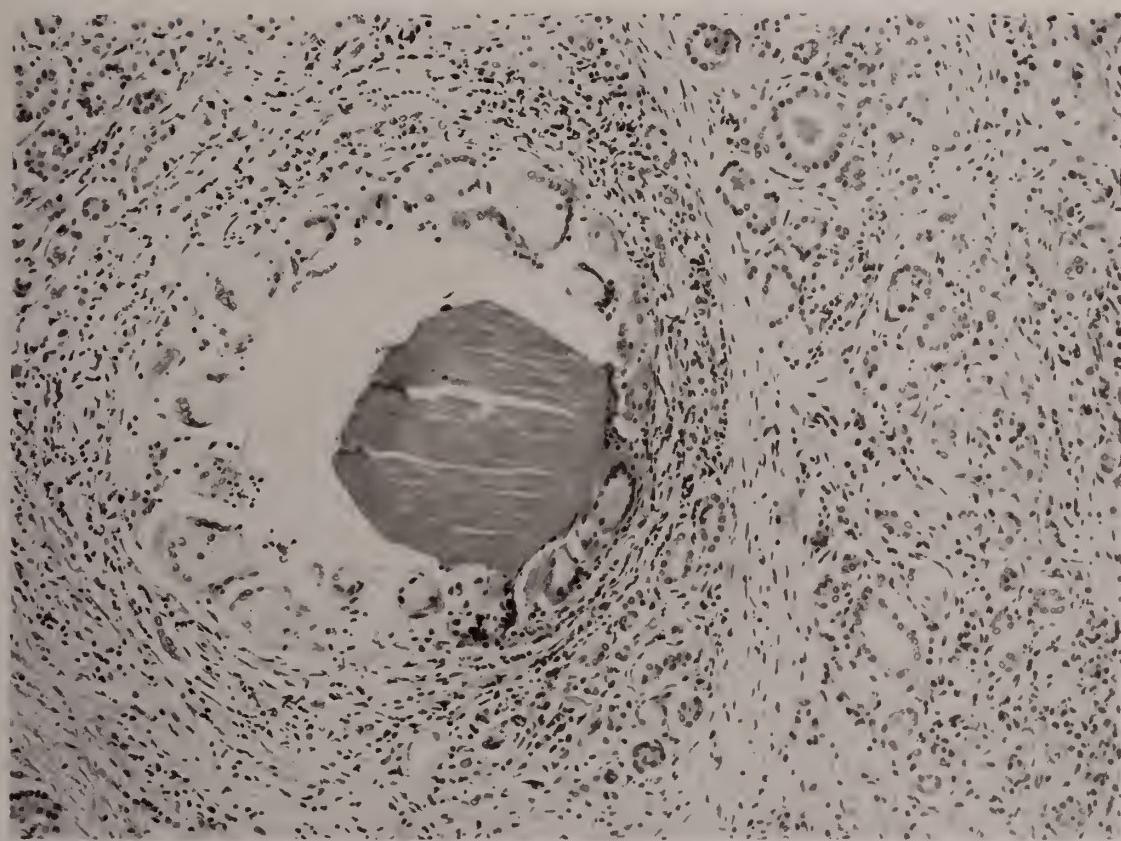


Fig. 3. Riedel's struma with giant cell formation. Cluster of giant cells, foreign body type, around a mass of dense colloid. Hematoxylin and eosin X 142.

been markedly adherent to neighboring structures in 50 per cent of the cases reported. Metastasis does not take place. There is no cachexia, nor is there a tendency to hyperthyroidism. Complete recovery usually follows the operation.

In the differential diagnosis, microscopic examination is usually necessary. Carcinoma is as a rule nodular, and Riedel's struma is generally a smooth enlargement.

The treatment consists in the elimination of all focal infections and more or less complete removal of the gland, which is often difficult because of adhesions. Roentgen therapy together with partial removal has been beneficial in some cases.

#### REPORT OF CASE

In February 1943, Mrs. N. R., a housewife aged 37, complained of pain in the neck in the region of the thyroid gland, which was associated with a considerable degree of nervousness and inability to sleep. Three weeks later a small nodule the size of a walnut appeared on the right side of the neck under the sternocleidomastoid tendon. She sought medical aid and was told by her physician that she had a gland from an infected tooth. The tooth was extracted, but the swelling was unrelieved. She was then treated for sinus infection. Three weeks later the enlargement, according to the patient, gradually transferred itself to the left side and was associated with much pain in the thyroid region, and especially about the jaw and neck. The patient had al-

ways been nervous and easily upset. She had never had tremor, but had experienced palpitation and fluttering in the region of the heart for about six years, and also "smothering sensations."

Physical examination revealed a slightly undernourished woman complaining of the symptoms described, together with loss of appetite and weakness, aggravated by exercise. The loss of weight was 10 pounds. The temperature ranged from 99 to 101 F. There was no tremor or palpitation of the heart. In the thyroid gland there could be felt a nodule about the size of a man's thumb, which was extremely hard and seemed to occupy the left lobe. It was tender. There was some evidence of dyspnea, especially with the patient lying down. No other signs or symptoms referable to the thyroid could be elicited.

The patient complained of piles, and since these were annoying, she was operated on. Three internal hemorrhoids were removed on May 3. The laboratory findings at this time showed a basal metabolic rate of +10 per cent and a cholesterol determination of 135. The reaction to the Goetsch test was negative. The administration of Lugol's solution failed to make any difference in the clinical symptoms.

A diagnosis of Riedel's struma was made, and on May 17 the left lobe of the thyroid and the isthmus were removed. These structures were extremely hard and fibrous. They were adherent to the neighboring structures in the neck, even to the trachea. The rather fibrous woodlike hardness extended a short distance up and down along the inferior and superior thyroid vessels, making dissection difficult. The right lobe of the thyroid was practically nonexistent, the isthmus shading off into a thin layer of thyroid tissue of dense consistency, closely adherent to the right aspect of the trachea. This would amount to about one eighth of the gland and was not removed. Recovery was completely uneventful, and the symptoms were relieved almost at once.

Pathologic examination of the tissue showed a white compact homogeneous gland. There was no evidence of malignant disease, and the sections were characterized by a large amount of replacement fibrosis. There was infiltration throughout, with chronic inflammatory cells and corresponding destruction and replacement of parenchyma. Throughout the sections there were many enormous pseudo giant cells grouped around masses of colloid. The pathologic diagnosis was Riedel's struma.

The basal metabolic rate on June 28 was —16 per cent. The cholesterol determination was 208. The patient was gaining weight and was entirely free of symptoms. On November 1 the basal metabolic rate was plus minus 1. At that time there were no physical findings of significance in the neck, and the patient was entirely well.

#### CONCLUSION

A case of chronic thyroiditis (Riedel's struma) of unknown etiology, involving the entire thyroid and apparently traversing it with partial destruction of the right lobe, is reported. The surgical treatment of the case is described.

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#### HYPODERMIC MEDICATION SHOULD BE PAINLESS

FREDERICK J. WALTER, M. D.  
SAN DIEGO, CAL.

How frequently the physician hears his patients say that they will take anything he may wish to give them by mouth, but they add, "I will not take medicine by hypodermics." These needle-shy persons have usually had experiences causing this revulsion. In many instances the physician has been to blame. In consequence, I have taken particular pains to perfect my technic until patients now say, "Why, doctor, I didn't know that this treatment could be so painless!" Or perhaps they may say, "I didn't know when you gave it to me."

In modern medicine more and more drugs are given intravenously and subcutaneously. It behooves physicians to keep their patients until they feel they have had sufficient medication for any proper course in a given case. I am satisfied that on account of lack of attention to little details they are losing many patients because they hurt them.

The more the physician uses a syringe the more he is apt to have rusty, choked, or too large needles. He should not let the needles be improperly cared for. With the newer drugs, the sulfa drugs, more transfusions and penicillin coming along, requiring the use of needles every few hours in their administration, it is of great importance to watch and guard against creating needle-shy patients. When my patients say to me that no one has hurt them so little in giving hypodermics, I naturally am complimented and gratified. These patients stay with me and send others.

Infinitely greater results can be obtained in giving vitamin B<sub>1</sub> and scores of other medicines by hypodermic medication. The physician sees his patient as frequently as may be necessary and gets better cooperation by this method of treatment. The simple truth is that the nurse and the physician should faithfully watch the needles, always carefully inspecting the points and keeping them razor-sharp. It is advisable always to use as small a needle as possible and to insert it as quickly as possible. Of course one should always try to find an area away from important nerves. A fold of the skin firmly held and pressed above the point of insertion will make possible the quick and painless flashlike jab that

is important. Then one should give the injection slowly.

One sees needles in use, over and over, with turned-up points, rusty perhaps and much too large for painless medication. A thoughtful physician will not be guilty of using such needles.

After all, the physician is after results. It is, therefore, of prime importance that he observe these simple details if he is going to keep his patients, give them all the treatment they should have and end with their singing his praises.

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#### CLOSER COOPERATION BETWEEN THE MEDICAL AND DENTAL PROFESSIONS

ROSCOE D. CUMMINS, D.D.S.  
ST. PETERSBURG

Mr. President and Members of the Pinellas County Medical Society:

May I now express to you my appreciation of the numerous times that I have been a guest at the meetings of your Society during the past eighteen years? I can honestly state that these occasions were of real value to me for they were informative and, to my mind most important, they gave me a definite and concise view of some of the problems of medicine as you yourselves see them.

The round table discussions, case histories and papers illustrated with lantern slides which I have heard and seen in your meetings have held two true values for me: (1) professional knowledge and (2) the comforting thought that here is another profession which approaches its problems with an open mind, honestly confesses its sins and immediately attempts to correct the cause of error.

Now, never having attended a meeting of osteopaths, chiropractors, naturopaths, metaphysical physicians and faith healers of various classes, I will have to say arbitrarily that to my knowledge there are only two professions that have something in common, those of medicine and dentistry. As a matter of fact, it is significant how similar the basic training is in the two distinct professions to the point where we branch off to become dentists. I might say here, that the specialized training we receive as dentists includes no courses in physical or mental jujitsu, but is limited entirely to the subjects accepted as the

proper therapeutics and surgery for the maintenance and restoration of oral health.

In assuming that the teeth and the adjacent structure compose the field of practice for the dentist, we must keep in mind that many pathologic conditions manifested in the mouth are not of local origin and therefore not in the scope of dental practice. The oral manifestations of tuberculosis, syphilis, renal disease, blood dyscrasias and many other diseases are illustrative. On the other hand, you have many patients who are restored to normal health after oral infections are cleared up, even though they complain of all known and many unknown pains and symptoms. On the basis of this interlocking of the practice of our professions I ask your indulgence in taking you into the field of dentistry as it pertains to our mutual efforts.

Roughly, we can divide dentistry into two phases, (1) dental medicine and surgery, and (2) operative or restorative dentistry. In the field of dental medicine and surgery is where we have common ground and where there is frequently the need of close collaboration of the two professions. The dentist over a period of several years has been increasingly called upon by his patients to find the source of their troubles. It is too true that in some of these cases the dentist alone has made a diagnosis without consulting, or having the patient consult, his physician, with the result that the patient is not benefited and is unnecessarily made a dental cripple. These are cases in which oral pathologic manifestations are secondary to other systemic causes. This sort of procedure is not good for the patient, is a slur on the profession of medicine and certainly is not good for the dental profession. In our literature you will note that such procedure is unqualifiedly condemned. The dentist who views the teeth and their adjacent structure as a separate entity, divorced from the rest of the body, receives our sharp criticism, and we hope will also receive yours.

Now the dentist has another problem in this field, and that is the patient who comes in stating with finality, "My doctor says my teeth must be pulled." The dentist then has a problem which can encompass all the known griefs of practice. Too many times we find that the diagnosis and suggestion were based either on a casual glance at the teeth or on failure to examine the patient thoroughly. It makes a bad situation, which does not reflect creditably on either the medical or the

dental profession, particularly if the patient later discovers the true cause of his trouble to be anemia or a thyroid disturbance. In some patients in the older age brackets we have observed seeming miracles in the relief of dental and general symptoms as a result of your administration of the proper sex hormones.

We have another problem in the diagnostic field, and that is in regard to dental roentgenograms. Let us assume that there have been instances in which a smart salesman has sold a dentist an x-ray machine with instructions, which consisted of how to turn it on and off and a few suggestions on angulation. Let me assure you that cases of this sort are few and far between and that the majority of the dentists doing this work are fully capable of interpreting the roentgenograms. Unfortunately, we still have requests from physicians via the patient to send them the dental roentgenograms. Frankly, in my experience I have not found anyone untrained in making a diagnosis from dental roentgenograms capable of doing so, and neither have I observed anyone in the dental field competent to make diagnoses from roentgenograms of the chest, gastrointestinal tract, or other areas not in the dental field.

We could go on at length with this subject, using case histories; however, the purpose of this paper is merely to bring to your attention briefly some of the high spots where we are not giving the patient the full benefit of your knowledge and ours. Dentistry up to the present is not encumbered with the parasitic "isms" with which you have to contend. We believe that

mutual cooperation between the professions of dentistry and medicine will not only give better results for the patient, which is the important point, but will also assist physicians in clarifying the public mind on who is qualified to practice medicine, the Doctor of Medicine, or the doctor of chiropractic or naturopathy.

Recently at a conference of a committee of the American Dental Association we were startled to learn that on many posts and stations of the armed forces the cooperation between the medical and dental officers was anything but what it should be. The lack of collaboration was truly serious in some areas, we were told. Such a situation is bad when you stop to consider the thousands of men who are passing through the hands of these officers and the resultant effect when they return to civilian life. I am glad to be able to report that steps were immediately taken by the office of the Surgeon General to correct this lack of cooperation, and later investigation has shown greatly improved conditions. Just as a matter of information, the rapid promotion during the last year or two in the dental corps has been due to the increase in dental surgeons authorized and has not been at the expense of withholding promotions for medical officers.

In conclusion, I should like to make one recommendation that certainly could do no harm and has possibilities of paying dividends. Why do not the medical and dental societies have a round table discussion on mutual problems, say once, twice or more times a year? Such meetings might prove of value to the members of both professions.

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JUNE 19 THROUGH JUNE 24, 1944

REPORT OF 661 NAIL PUNCTURE WOUNDS OF THE FOOT, BOWEN, FRED H., JACKSONVILLE, J. A. M. A. 119: 413-414 (MAY 30) 1942.

A simple plan of treatment of nail puncture wounds of the foot is described, which is in contrast to probing the wound, laying it open, injecting an antiseptic solution and instituting drainage, as most frequently advocated. The author regards this treatment as unnecessary, painful and harmful, and he observes that it is followed by prolonged disability and occasionally by a painful plantar scar.

He demonstrated experimentally that in such wounds foreign bodies lie in the dermis or just beneath it, the nail (6 to 20 penny) being wiped clean in the proximal  $\frac{1}{4}$  inch of the tract. Also, he noted that introducing a drain into a noninfected wound tends to convert it into an infected wound. He established that the tract made by nail wounds resembles a staircase more than a straight line in so complex an anatomic unit as the foot and concluded that probing is harmful because it often does not follow the course of the original nail wound, causes injury to tissue not injured by the nail and opens new tissue planes to infection.

The treatment described consists of painting with tincture of mercresin an area from 2 to 3 inches in diameter around the wound after the foot has been soaked for fifteen to thirty minutes in hot water to which liniment of soft soap (tincture of green soap) or a small quantity of saponated solution of cresol has been added. When the foot has been carefully dried, the foreign matter is exposed by grasping the wound edges with splinter forceps and cutting away the epidermis for several millimeters about the circumference of the wound; it is then easily removed with the splinter forceps or wiped away with a cotton applicator soaked in tincture of mercresin. The wound is probed under direct vision and not beyond  $\frac{1}{4}$  inch. A dry dressing is applied, and 1,500 units of tetanus antitoxin is given.

In a series of 661 cases of nail puncture wounds of the foot treated by this method, no deaths occurred, no tetanus was encountered, and there was a disability per case of only 0.6 day. If the wound was caused by a nail smaller than a 10 penny, the patient returned to work at once with instructions to soak his foot in hot water for thirty minutes on reaching home and again at bedtime. If a larger nail caused the injury, the patient was instructed not to work for a day or two, and patients with severe nail wounds

were told not to bear weight on the affected foot for a similar length of time. If evidence of increasing inflammation was observed, elevation and rest of the affected limb and the application of hot compresses were advised. No prophylactic sulfonamide treatment was used either locally or orally.



EPIDERMOID CARCINOMA OF THE ANUS AND THE RECTUM, CATTRELL, RICHARD B., AND WILLIAMS, ASHBEL C., BOSTON, ARCH. SURG. 46: 336-349 (MAR.) 1943.

The pathologic and clinical aspects of epidermoid, or squamous cell, carcinoma of the anus are summarized, and emphasis is placed on the considerations governing treatment. It is suggested that the disappointing results responsible for the conception of this highly malignant tumor as offering a poor prognosis regardless of the treatment employed, may be due to inadequate therapy rather than to an inherent incurability of the lesion.

The incidence of squamous cell carcinoma is estimated as less than 5 per cent of all rectal and anal tumors and is greatest in the sixth decade of life although there is wide variation in age. Antecedent lesions have been established as important causative agents. There is no characteristic syndrome, but rectal pain, occurring chiefly at stool, is the most frequent presenting symptom.

Attention is directed to the wide variation in the gross appearance of this type of epidermoid carcinoma, for it may simulate a fistula, fissure, chancre, condyloma or hemorrhoid, or any other anorectal disease, including, of course, adenocarcinoma. It is possible to establish positive diagnosis only by microscopic sections. Microscopic study of all anal and rectal lesions is urged in order to avoid overlooking the presence of carcinoma.

Great emphasis is placed on the importance of the manner of spread of this disease, both locally and by metastasis, as this is the basis for treatment. Locally, invasion of the sphincter ani muscles, the perianal tissue, the rectovaginal septum or the prostate gland may take place, or the course may be upward into the rectal wall and rectum. Metastasis occurs commonly by way of lymphatics, and the routes of spread are well known; rarely it is blood borne. The possible or actual presence of lymphatic metastases is regarded as most important in the formulation of any plan of treatment. It is pointed out that the great frequency of epidermoid metastases makes

it incumbent upon the physician to regard every patient with epidermoid carcinoma of the anus as having metastases, which occur almost without exception in the downward and lateral zones of spread described by Miles and in the inguinal lymph nodes. The authors regard failure to recognize and provide for these possibilities in the plan of treatment as prominent causes of poor end results.

In 9 of the 10 cases in the series presented the growth was anal; in 1 case the tumor occurred in the rectosigmoid. In all, treatment was by operation alone. Six of the patients were well after from six months to ten years and a seventh was living with extensive metastases to the groin.

After reviewing the various methods of therapy, the authors conclude that radical operation offers the best prognosis, regardless of the histologic gradation of the tumor, and advocate a surgical approach consisting of a Miles abdominoperineal resection and a radical inguinal dissection for every operable growth. They deplore the employment of local excision alone for so-called favorable lesions as courting recurrence and a fatality in more than 50 per cent of the cases and believe that five year survival rates should rise from 60 per cent to 80 per cent with the acceptance of radical operation as the method of choice in every case. They recommend irradiation for inoperable lesions and for recurrences following operation. In their opinion end results following both types of therapy would doubtless be much improved if radical methods were instituted and standardized.

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville 1, for abstracting in this department.*

BLADDER NECK OBSTRUCTION CONGENITAL IN YOUNG MALES; INFLAMMATORY IN FEMALES; REPORT OF 2 ILLUSTRATIVE CASES, LOEB, MARTIN J., NEW YORK, UROL. & CUTAN. REV. 44: 455-460 (JULY) 1940.

The author discusses the views of various writers regarding the question of whether median bar obstruction in male children is congenital in origin or is caused by a chronic inflammatory condition. He observes that the patients with this syndrome, termed renal infantilism by Beer, have the pale, pasty complexion characteristic of patients with chronic nephritis and show a lack of growth of hair on the face. The urinary stasis naturally causes pyuria and pain, and a cystogram shows a space between the symphysis pubis and the dye-filled bladder.

He notes that congenital conditions causing obstruction may be observed in boys, or may first be noticed in young adults when the patient seeks relief for dysuria. Treatment consists of cystostomy, cutting out the obstructing flaps, or transurethral resection of the median bar if an instrument can be passed.

Dr. Loeb agrees with most observers that obstruction of the neck of the bladder in women is caused by epithelial hyperplasia, some fibrosis and subepithelial edema, the result of a chronic inflammatory process. Cystitis is present in this condition; purulent material adheres to the wall of the bladder or floats in the fluid filling it; cellules and trabeculations occur commonly. Owing to urinary stasis, there may be stones in the bladder. Also, pyelonephritis and pyohydro-nephrosis caused by reflux of the urine may occur.

The patient has the pasty complexion of the person with chronic nephritis and seeks relief because of dysuria, frequency, nocturia, incontinence, or overflow. Transurethral resection effects permanent relief, but such palliative measures as irrigation of the bladder with solutions of acriflavine or permanganate and dilatation of the urethra by sounds may afford temporary relief.

The two cases presented are typical clinically, pathologically and roentgenologically of obstruction of the neck of the bladder as it occurs in the two classes of patients.

MESENTERIC CYSTS; REVIEW OF LITERATURE, GENESIS, AND CLASSIFICATION; REPORT OF A CASE, LOEB, MARTIN J., NEW YORK, NEW YORK STATE J. MED. 41: 1564-1569 (AUG. 1) 1941.

After briefly reviewing the history of mesenteric cysts by periods and estimating the frequency of their occurrence by the 8 or 10 cases reported annually, Dr. Loeb discusses their genesis, classification, location, diagnosis, objective signs, symptoms, complications and treatment. He defines a true mesenteric cyst as one that occurs between the two layers of the mesentery or beneath the serosa of the intestine; it is not malignant, dermoid, or parasitic, nor does it arise from any normally placed retroperitoneal organ or from embryonic rests although through growth it may make its way into the mesenteric space. Also, he presents a new interpretation of the classification of Dowd and Niosi.

Since symptoms are indefinite and roentgen examination usually yields practically negative results, a diagnosis in the early stages is impossible. The symptoms are those of the complication, which may be subacute or acute intestinal obstruction, peritonitis occurring either as a sequel to intestinal obstruction or because of rupture of the cyst into the peritoneal cavity, hemorrhage, torsion of the cyst, or its incarceration within the pelvic cavity.

In the later stages the tumor may be located in the midabdomen; it is movable, cystic and surrounded by tympanitic areas. Occasionally it is demonstrable roentgenologically.

Enucleation is the treatment of choice, but in some cases resection of the cyst with the portion of intestine strangulated within it is necessary, and in others marsupialization is required.

In the case reported, roentgen examination revealed gas in the small intestine and the faint shadow of an intra-abdominal mass the size of a grapefruit. The preoperative diagnosis was subacute intestinal obstruction of unknown etiology. A large cyst, springing from the mesentery, and about 6 inches of the small intestine, entangled and imbedded in this mass, were resected with successful outcome.

COMBINED PENICILLIN AND HEPARIN THERAPY OF SUBACUTE BACTERIAL ENDOCARDITIS; REPORT OF SEVEN CONSECUTIVE SUCCESSFULLY TREATED PATIENTS, LOEWE, L.; ROSENBLATT, P.; GREENE, H. J., AND RUSSELL, M., BROOKLYN, J.A.M.A. 124: 144-149 (JAN. 15) 1944.

The apparently successful treatment by use of penicillin in conjunction with herapin of 7 patients with subacute bacterial endocarditis, a condition almost invariably fatal, is reported. The authors state that although further observation will be required to determine the permanence of results, the immediate effects suggest uniformly successful sterilization of the blood and relief of clinical manifestations. With regard to former modes of therapy the authors state:

In experimental thrombotic bacterial endocarditis, the disappearance of vegetations requires the use of a suitable chemotherapeutic agent and an anticoagulant. The clinical application of this principle in subacute bacterial endocarditis has been disappointing; the technics of therapy are cumbersome, the toxicity of treatment has been excessive even for an otherwise fatal disease and the successes have been few and irregular. Early efforts made with sulfonamides, with or without heparin, have been mostly abandoned. The introduction of penicillin proved equally disappointing; the commission appointed by the National Research Council has already reported unfavorably and discouraged the use of the at present inadequate supply of the drug for the treatment of viridans endocarditis. The present report... employs variations on previous technics.

The penicillin was given in requisite dosage by continuous intravenous drip in 6 cases; in 1 case it was also administered intramuscularly. The heparin was deposited beneath the skin in most instances, but occasionally was incorporated in the venoclysis.

Six of the 7 patients suffered from a bacterial endocarditis that was engrafted on a chronic rheumatic valvulitis, and the other had a congenital cardiac defect. In 5 of the 7 patients the etiologic organism was a Streptococcus viridans; the sixth patient had a hemolytic streptococcus and the seventh a pneumococcus type 27.

The efficacy of the therapy may have been enhanced in a few cases by the preliminary use of sulfonamide, which was given to all 7 patients.

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**NEWLY ELECTED OFFICERS**

Dr. John R. Boling of Tampa assumed the presidency of our Association at the close of the seventy-first annual meeting, at noon on April 14. Officers elected at the closing session were: Dr. Shaler Richardson, Jacksonville, president-elect; Dr. W. C. McConnell, St. Petersburg, first vice president; Dr. Horace A. Day, Orlando, second vice president; Dr. Robert D. Ferguson, Ocala, third vice president; Dr. Robert B. McIver, Jacksonville, secretary and treasurer; and Dr. Homer L. Pearson, Miami, editor of the Journal. The personnel of standing committees, including Dr. Boling's new appointees, appears on the preceding page of this Journal.

Inasmuch as this issue was in press before the annual convention convened, the proceedings of the various sessions will appear in the June Journal.

**AETNA LIABILITY POLICY STILL IN EFFECT**

Several of our members who hold physician's and surgeon's liability certificates with the Aetna Casualty and Surety Company under our group policy have been led to believe that it is not possible to carry malpractice insurance with the Aetna after the expiration of their present certificates.

The group or master policy of our State Association with the Aetna Casualty and Surety Company is still in effect. It has not been cancelled or withdrawn.

In some instances the local agent or agents of the Aetna have been changed. In such instances the Aetna is required to notify the insured member on the thirty-day proviso that his certificate terminates. However, such member

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of the Association is at liberty to contact an authorized local agent of the Aetna and make new arrangements for a certificate under the provisions of the master policy. This confusion results from the fact that expirations are the property of the local agent who originally issued the certificates.

Any member who receives the required thirty days' notice that the Aetna is unable to renew the coverage provided in his certificate should immediately contact a local agent of the Aetna Casualty and Surety Company, and secure another certificate.

Naturally a local agent who no longer represents the Aetna Casualty and Surety Company may try to influence our members to take coverage in some other company which he represents. If a member wishes to change to some other company, that is his privilege. However, it is also his privilege to continue with the Aetna if he so desires.

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Hastings	Ansley Hall	Lock Drawer "I."
Jacksonville	Diamond Insurance Agency	Graham Bldg.
Jacksonville	Roger M. Painter & Company	P. O. Box 83
Lakeland	H. H. Alssopp	301 Marble Arcade Bldg.
Lakeland	H. J. Drane	311 E. Main St.
Lake Wales	Douglass B. Bullard	221 E. Stuart Ave.
Lake Worth	Erle H. Wilson	10 S. Dixie Highway.
Largo	Largo Insurance Agency	64 Second St., S. W.
Melbourne	Lathrop-Lux-Kerr, Inc.	P. O. Box 306.

Miami—Stembler-Adams-Frazier Ins. Agency, 100 N. E. First Ave.  
 Miami Beach—C. L. Clements, 1111 Lincoln Road.  
 Mount Dora—Sadler & Simpson, 116 E. Fifth Ave.  
 Orlando—Theodore J. Lindorff Agency, P. O. Box 1126.  
 Orlando—Wise & Brass, Inc., P. O. Box 2014.  
 Palm Beach—Claude S. Reese Agency, 420 Royal Palm Way.  
 Pensacola—Sam Rosenau Agency, 500 Amer. Nat. Bank Bldg.  
 Punta Gorda—Perkins Insurance Agency, P. O. Box 965  
 St. Petersburg—L. N. Wade & Co., 476 First Ave., N.  
 St. Petersburg—The Wallace Agency, 716 4th St. N.  
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 Sarasota—Ludwig-Walpole Company, P. O. Box 869.  
 Tampa—Warren Bros., Henderson & Smith, 1305 First Natl. Bank Bldg.  
 Vero Beach—Buckingham-Wheeler Agency, P. O. Box AA.  
 West Palm Beach—Charles R. Dorsey, P. O. Box 1186.  
 West Palm Beach—Gane & Wagner, 211 S. Olive St.



### MEDICAL POSTGRADUATE COURSE

The annual postgraduate short course for doctors of medicine in Florida will be held at the George Washington Hotel, Jacksonville, from June 19 to 24, inclusive. This meeting will be conducted by the Medical Department of the Graduate School of the University of Florida, in cooperation with the Florida Medical Association and the Florida State Board of Health.

The faculty will consist of outstanding educators, several of whom will be new to this course. Dr. Samuel F. Ravenel will return to deliver the lectures on pediatrics. Dr. Eugene Stead, professor of medicine of Emory University, will lecture on medicine.

The program in general will be similar to those of previous years, although twelve new lectures have been added this year, four on postwar medicine, four on postwar surgery and four on postwar public health. In order to provide a place for these extra lectures, evening sessions will be held at each of which two lectures will be given. Dinner meetings will not be held this year.

If any physician needs assistance in making hotel reservations, he should communicate with the chairman of the committee. As usual, doctors in uniform will be admitted without the payment of a registration fee.



### WHAT IS WRONG?

Why do so many of our young graduate nurses fail to pass their Florida State Board examinations? One might shrug and ask: "Is this any of our business as physicians?" We feel that it is most emphatically our business, and that we have shirked our responsibilities too long.

In the practice of medicine as developed in this country, the nursing profession and medical profession have become mutually interdependent as well as integral parts in treating the sick. Perhaps we as physicians did not realize the importance of the "Junior Partner" until the needs of the armed services caused such an acute shortage of nurses at home. But now we are feeling the pinch and bestir ourselves. We were amazed to learn that for the years 1940-43 inclusive—we did not go back further—forty per cent of all applicants failed to pass their Florida State Board Examinations. Those who failed were all recent graduates of the nurses' training schools throughout the state. This is an amazing wastage at any time. Now when there is such a critical and desperate need for nurses both for the armed forces and civilians, some authority should ascertain the reasons and institute remedial measures at once.

At this stage we do not possess enough accurate information to point an accusing finger in any certain direction, but being in an inquiring frame of mind, certain thoughts do arise. Everyone must admit something is wrong when forty per cent of applicants fail any examination.

Is it the fault of the methods of instruction in the training schools? If only one—possibly two—of the training schools in the state furnished the failures, we would be inclined to agree, but the failures are general in all the schools and have been repeated year after year. Are the standards set by the Board of Examiners wrong? Since it is the established policy of the Board not to give out the questions, we have not seen the complete tests covering the years under consideration. But from some of the questions quoted by many examinees and from the bare fact that forty per cent fail we must conclude that the examinations given by the Board are impractical.

If this is true, then we must seek the reason. We know the Board does not wish to have such a high percentage of failures. Is it possible that there is not an adequate liaison between the training schools and the Board? Student nurses are taught jointly by recognized Instructors and members of the Medical Staffs. Both of these groups keep abreast of clinical practice on a current basis and teach accordingly. Members of the State Examining Board are appointed by the Governor for a term of four years. Unless a good percentage of such members are closely associated with teaching institutions, no matter what their personal ability and qualifications, they are out of touch.

The students are taught by one group—the members of the medical staffs and the Instructors—and examined by a different group. Unless there is a close tie-up between the two groups, how can the Examiners present a list of questions that will fairly ascertain the student's knowledge of the subjects taught? And surely that is the only fair examination.

We have presented these thoughts in a spirit of constructive criticism and in an investigative frame of mind hoping that some interested authority will take action to correct the fault or faults that year after year cause forty per cent of applicants to fail the Board.

As a starter may we suggest the following points to be considered: (1) That the Florida State Board of Examiners for Nurses be composed of members who are actively and currently associated with recognized training schools; (2) That questions in some manner be evolved from subject matter taught students currently; (3) That there be some liaison between the members of the Examining Board on the one hand and instructors and members of the Medical Faculties on the other.

WAR SESSION OF  
AMERICAN COLLEGE OF SURGEONS

A one day War Session of the American College of Surgeons convened on Monday, April 27, at Jacksonville. Dr. Frank K. Boland of Atlanta, Governor of the College, opened the meeting. In attendance were physicians from Florida, Georgia, Alabama and South Carolina.

Interesting military motion pictures were presented which showed the activities of the medical department of the U. S. Army in the many theatres of war. Those present were impressed with the rapidity with which emergency hospital units are set up after invasion, and the prompt and efficient treatment which our men receive under conditions of battle.

Capt. Don S. Knowlton presented an excellent dissertation on his experiences in the theatres of operations, especially in the South Pacific. He paid high compliment to the organization of the medical departments of the Army and Navy.

At the luncheon, presided over by Dr. James M. Mason of Birmingham, many problems were discussed. One of the most important was that raised by Dr. Kenneth M. Lynch of Charleston, who spoke on "Current Problems in Relation to the Accelerated Program for Premedical and Medical Education."

A dinner-forum was held at 6:15 p.m., presided over by Dr. Frederick J. Waas of Jacksonville, moderator. Special problems which today face physicians and hospital executives were discussed.

Another feature of the meeting was an exhibition of paintings by Major Bosworth, showing that even under conditions of battle one may pursue a hobby as a relief from strain. These pictures were well executed and provoked a great deal of interest and discussion. It was pointed out that in times of stress, each physician should have a hobby as a respite from strain and worry.

On Sunday afternoon preceding the meeting, many physicians enjoyed a radio forum over WMBR dealing with the manpower situation as it pertains to hospitals, and how this problem is being handled.

The committee on local arrangements, of which Dr. Waas was chairman, feels that a great deal was accomplished and that this was a most profitable meeting.

RELOCATED PHYSICIANS TEMPORARILY  
LICENSED

Additional relocated physicians have been granted temporary licenses to practice medicine, each in a specified county in Florida, by the State Defense Council.

A certificate of need for such a physician must be filed by the county medical society or, in the absence of a county medical society, by the Board of Governors of the Florida Medical Association. These temporary licenses are subject to revocation by operation of law or by direction of the Governor, but in no event shall they continue in effect longer than six months after the end of World War II. Further information concerning the procedure may be found in the March, 1944 issue of the Florida Medical Journal.

NAME	T. L.	COUNTY
G. H. Buck, M.D.	No. 14	Alachua
W. R. North, M.D.	No. 15	Sarasota
W. C. Howell, M.D.	No. 16	Bay
Irving J. Warmols, M.D.	No. 17	Polk
Don J. Royer, M.D.	No. 18	Palm Beach
Margaret Whiteside, M.D.	No. 19	Leon

## BIRTHS, MARRIAGES AND DEATHS

## BIRTHS

Dr. and Mrs. Paul H. Martin of Jacksonville announce the birth of a son, George Gilmore, on March 4.

Dr. and Mrs. Walter E. Murphree of Gainesville announce the birth of a son, Walter Ellis, II, on February 23.

Dr. and Mrs. Walker Stamps of Jacksonville announce the birth of a son, Thomas, on April 3.

Dr. and Mrs. G. H. Putnam of Sanford announce the birth of a daughter, Martha Ann, on April 23.

## MARRIAGES

Dr. J. H. Lucinian and Mrs. B. Edna Roberts of Miami were married on December 25, 1943.

## DEATHS

Dr. Henry E. Palmer of Tallahassee died on March 22. Dr. William E. Whitlock of High Springs died on April 5.

## STATE NEWS ITEMS

**FOUND**—A leather zipper case, size about 10 by 15 inches, was left at the registration desk at the Princess Martha Hotel, April 13, during the State Association's annual convention. At the close of the convention, it had not been called for. Owner please describe its contents for identification. Write Box 1018, Jacksonville 1, Fla.

The Florida Board of Examiners in the Basic Sciences will hold its next examination June 8, 1944, at the University of Florida, Gainesville. Application blanks may be obtained from J. F. Conn, Ph.D., Secretary, DeLand.

The State Board of Medical Examiners will hold its next examination June 26 and 27, 1944, at Jacksonville. Application blanks may be obtained from Dr. W. M. Rowlett, secretary, Tampa.

Dr. Walter C. Jones of Miami was appointed in March to a three year term as a member of the Merit System Council of the Florida State Board of Health and the Crippled Children's Commission.

Dr. O. E. Harrell of Jacksonville spent the month of April at Harvard Medical School, taking a postgraduate course in obstetrics and gynecology.

Dr. Miles A. Collier of Miami announces the opening of his office in the Huntington Building. He will limit his practice to obstetrics and gynecology.

Negro doctors of medicine in Florida will be invited to attend the lectures of the Medical Post-graduate Short Course this year as they have been in the past few years. They will be registered by the Graduate School of the Florida Agricultural and Mechanical College. The meeting is scheduled to be held from June 19 to 24, inclusive, at Jacksonville. Refer to the editorial in this Journal for additional information.

Dr. Fuad Hanna of Miami announces the opening of his office at 1299 Brickell Avenue. Dr. Hanna returned recently from military service.

## HENRY EDWARDS PALMER

Dr. Henry E. Palmer, Life Member and past president of the Florida Medical Association, died at his home in Tallahassee on March 22, 1944, at the age of 78.

Born at Monticello, Florida, on September 30, 1866, the son of Samuel Augustus and Mary Amelia Gassaway Palmer, he grew up during the Reconstruction era, which meant hard times, disappointment and self denial to his parents as it did to all other Southerners. He began work at the age of 12 and from that time was entirely self-supporting. He attended Jefferson Academy until he was 17 years old, when he secured a position in a general merchandising store, which he held for six years. During this time he saved a sufficient sum to pay for one year's expenses at the medical school of the University of Maryland. He completed his medical training on borrowed money, graduating from that institution in April, 1892. Following his graduation he was appointed resident physician at the Hospital of the University of Maryland and later was placed in charge of the hospital ship stationed at Fortress Monroe in the mouth of the Chesapeake Bay.

In the fall of 1892 he accepted an invitation to take charge of the practice of Dr. George Betton of Tallahassee, while that doctor took a few weeks' rest. On Dr. Betton's return, Dr. Palmer became associated with him in a partnership which lasted for a number of years, after which Dr. Palmer established his own practice. Thus did his anticipated practice of a few weeks in Tallahassee lengthen into a stay of over half a century.

In the early days of his practice Dr. Palmer traveled the streets and roads of Tallahassee and Leon County by horse and buggy. He performed the first appendectomy in that district, the operation being made on a dining table in a private home, with the assistance of two neighbors who acted as nurses. He also performed the first operation in the city for ovarian tumor and his name is identified with the early treatment of black widow spider bite.

In 1894 Dr. Palmer was married to Maud Hamilton Myers of Tallahassee. Four children were born to the couple. The first Mrs. Palmer

died in 1903. In 1911, he was married to Sarah Lucille Saxon of Tallahassee and four children were born to them. The second Mrs. Palmer died in 1927. In 1938 he was married to Mrs. Leah B. Furlong of New York, the widow who survives. Dr. Palmer is also survived by two daughters and six sons, two of whom are physicians, Dr. Thomas M. Palmer of Jacksonville and Capt. George Saxon Palmer, who is overseas with the Army.

Dr. Palmer held many positions of honor during his long practice, among which was the presidency of the Florida Medical Association, to which he was elected in 1909. At various times he also served as county health officer, president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, president of the State Board of Medical Examiners, a member of the State Board of Health, president of the Association of S. A. L. Railway Surgeons, president of the Florida Railway Surgeons, and local surgeon for the F. R. & N., F. C. & P., and S. A. L. railways at Tallahassee for fifty years. He was a charter member and past president of the Tallahassee Kiwanis Club and a member and senior warden of St. John's Episcopal Church.

In his own words, "It has been a full, an active life. I have enjoyed it."

#### LYMAN LYNDON BUNKER

Dr. Lyman L. Bunker of Fernandina died on March 8, 1944. At the time of his death, he was a Major of the Medical Corps of the United States Army, retired.

Born at West Salem, Wisconsin, on August 6, 1876, he was the son of the Reverend William Bunker and his wife, Laurena Tichenar Bunker. He received his medical training at the St. Louis College of Physicians and Surgeons, from which he was graduated in 1909. He practiced in Enid, Oklahoma, until the outbreak of World War I, when, on April 21, 1917, he entered military service. He rose to the rank of Major, and was made surgeon in charge of the Biltmore Hospital No. 12 at Asheville, N. C.

After his discharge from service in August of 1919, he moved to Fernandina, where he practiced until his death. For the past ten years he served as county physician of Nassau County. He was vice president of the Nassau County Medical Society, and a member of the Florida Medical Association and the American Medical Association. He was also a member of the First

Baptist Church, Amelia Lodge No. 47, F. & A. M., Fernandina Chapter No. 55, O. E. S., and Theodore H. Hernandez Post No. 54 of the American Legion.

On September 6, 1900, Dr. Bunker was married to Miss Lola Brasher of Upper Alton, Ill., who now survives him. Other survivors include four children and ten grandchildren.

Dr. Bunker was interested and helpful in all phases of public health and social service. As a true gentleman and splendid physician, he gained the highest respect and confidence of his friends and patients throughout Nassau County.

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#### MILLEN ALEXANDER NICKLE

Dr. Millen A. Nickle of Clearwater, 63 years of age, died on March 6, after an illness of two weeks. As a specialist in eye, ear, nose and throat work, he had practiced in Clearwater for twenty years.

Born in Madoc, Canada, Dr. Nickle received his medical training at the University of Toronto in Toronto, Canada, from which he was graduated in 1907. He continued his study at the Herman Napp Memorial Hospital in New York City, and on several occasions in later years took special postgraduate courses in connection with his specialty. He was a Fellow of the Royal College of Surgeons of Edinburgh, a Fellow of the American Medical Association, a member of the Florida Medical Association, the Pinellas County Medical Society, the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology. He was also a member of the Peace Memorial Presbyterian Church, the Clearwater Rotary Club, and the Clearwater Country Club.

Survivors include his widow, Mrs. Laura Holdcroft Nickle of Clearwater; one daughter, Mrs. H. P. Hayden of Clearwater; two brothers, the Rev. George Nickle, Toronto, and John Q. Nickle, Saskatchewan; and one sister, Mrs. John Davis Smithsville of Ontario.

Among the many tributes paid to the memory of Dr. Nickle was an editorial in the Clearwater *Sun*, in which it was said of him: "His was a useful life dedicated to the welfare of others. He was both a gentleman and a gentle man. There was no harshness in him. He did not know how to be unkind."

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**WILLIAM RICHARD WARREN**

Dr. William R. Warren, a native of Key West, died in that city on February 14, 1944, at the age of 67. He is survived by his widow, Mrs. Genevieve Warren; two sons, Captain William R. Warren, Jr., USA, Maxwell Field, Ala., and Lieut. George Allen Warren, USA, Camp Forrest, Tenn.; a daughter, Mrs. Joseph C. Wheeler, Jr.; a sister, Mrs. Susan Shourds of Miami, and a brother, Thomas K. Warren.

Dr. Warren, a descendant of one of Key West's prominent and pioneer families, received his early education at Dury Academy, North Adams, Mass. In 1900 he was graduated from Williams College in Williamstown, Mass., after which he entered the University of Pennsylvania, where he received his degree in medicine in 1904. He returned to Key West to establish a practice, which he continued until the time of his death. His marriage to Miss Genevieve Allen, daughter of the late George W. Allen and Mrs. Allen, was solemnized in 1911. During World War I, he served as a lieutenant in the Navy Medical Corps.

Dr. Warren was for many years vice president and director of the First National Bank of Key West. He was one of the oldest members of the Anchor Lodge of Masons, a charter member of the Rotary Club of Key West, a member of the Elks and the Woodmen of the World. He was also a member of the American Medical Association and the Florida Medical Association, and for many years served as secretary of the Monroe County Medical Society.

**BUY WAR BONDS****COMPONENT COUNTY SOCIETIES****BROWARD**

The Broward County Medical Society has paid 100% of its membership dues for 1944. Officers of this society are: president, Dr. John A. Johnston; vice president, Dr. Robert Blessing, and secretary-treasurer, Dr. O. C. Brown, all of Ft. Lauderdale.

**DADE**

A motion picture film, "Psychiatry in Action," was shown at the meeting of the Dade County Medical Society, held on Tuesday evening, March 7, at the Jackson Memorial Hospital, Miami.

**DUVAL**

Dr. J. G. Lyerly, president, was the principal speaker at a meeting of the Duval County Medical Society held on the evening of March 7 at St. Luke's Hospital, Jacksonville. He illustrated his talk on "Prefrontal Lobotomy" by lantern slides and motion pictures.

**JACKSON**

At the annual meeting of the Jackson County Medical Society, held February 14 at the Jackson County Hospital, Marianna, the following officers were elected: president, Dr. C. D. Whitaker, Marianna; vice president, Dr. R. L. Miller, Graceville, and secretary-treasurer, Dr. C. A. Adams, Jr., Marianna.

**MADISON-SUWANNEE**

This society has paid 100% of its membership dues for 1944. Officers of the organization are: president, Dr. Eustace Long of Madison, and secretary-treasurer, Dr. Eugene D. Thorpe, Madison.

**MANATEE**

The Manatee County Medical Society is on the Honor Roll of 100% paid societies. Officers of this organization are: president, Dr. S. G. Hollingsworth, Bradenton; vice president, Dr. Blake Lancaster, Manatee, and secretary-treasurer, Dr. L. W. Blake, Bradenton.

**MARION**

The regular meeting of this society was held Thursday, March 16, at the Hotel Harrington, Ocala. Dr. Robert D. Ferguson gave an informal talk on clinic and hospital subjects in connection with his recent trip to New Orleans. This talk was extremely interesting.

It is reported that Dr. J. W. McMurray of Williston has entered military service. It was de-



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cided to ask for honorary membership for Dr. Thomas H. Wallis. There were eight members present at this meeting.

Every member of this society has paid this year's state dues, so it is now in the 100% class.

#### PALM BEACH

The Palm Beach County Medical Society has paid 100% of its dues for 1944. Officers of this society are: president, Dr. James L. Carlisle; vice president, Dr. David W. Martin; secretary, Dr. Edgar W. Stephens, and treasurer, Dr. W. C. Williams, Jr., all of West Palm Beach.

#### PINELLAS

Drs. Prescott LeBreton and R. C. Lonergan presented a paper on "Low Back Pain" at the dinner meeting of the Pinellas County Medical Society held on the evening of March 3 at the Detroit Hotel, St. Petersburg.

On March 17 the members of this society held a round table assembly at the home of Dr. A. J. Bieker. Dr. Bieker acted as moderator. It was decided that no meetings of the society would be held during the month of April owing to the fact that the Florida Medical Association would hold its annual convention in St. Petersburg during the middle of that month.

#### ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN

All members of this society have paid their annual dues for 1944. Officers of the society are: president, Dr. M. D. Council; vice president, Dr. L. L. Whiddon, and secretary-treasurer, Dr. A. M. Sample, all of Ft. Pierce.

#### SEMINOLE

The regular meeting of this society was held in the Fernald-Laughton Memorial Hospital, Sanford, at 8 p.m., Tuesday, March 14. There was a general discussion regarding life and honorary membership, followed by a discussion of the prices allowed physicians by the United States War Labor Camp situated in Sanford.

An interesting round table discussion of the efficiency of the various methods of treating syphilis was entered into by all members present. Special attention was given to the new intensive forms of therapy.

Members present were: Drs. J. A. Smith, Leland H. Dame, Wade H. Garner, George H. Putnam and G. S. Selman.

This society is to be congratulated on having paid 100% of its membership dues for 1944.



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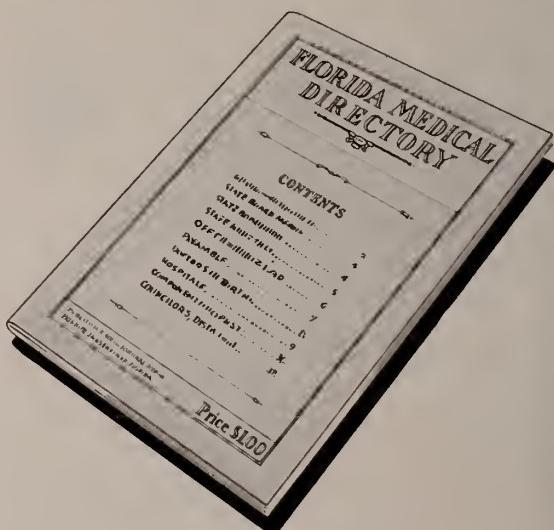
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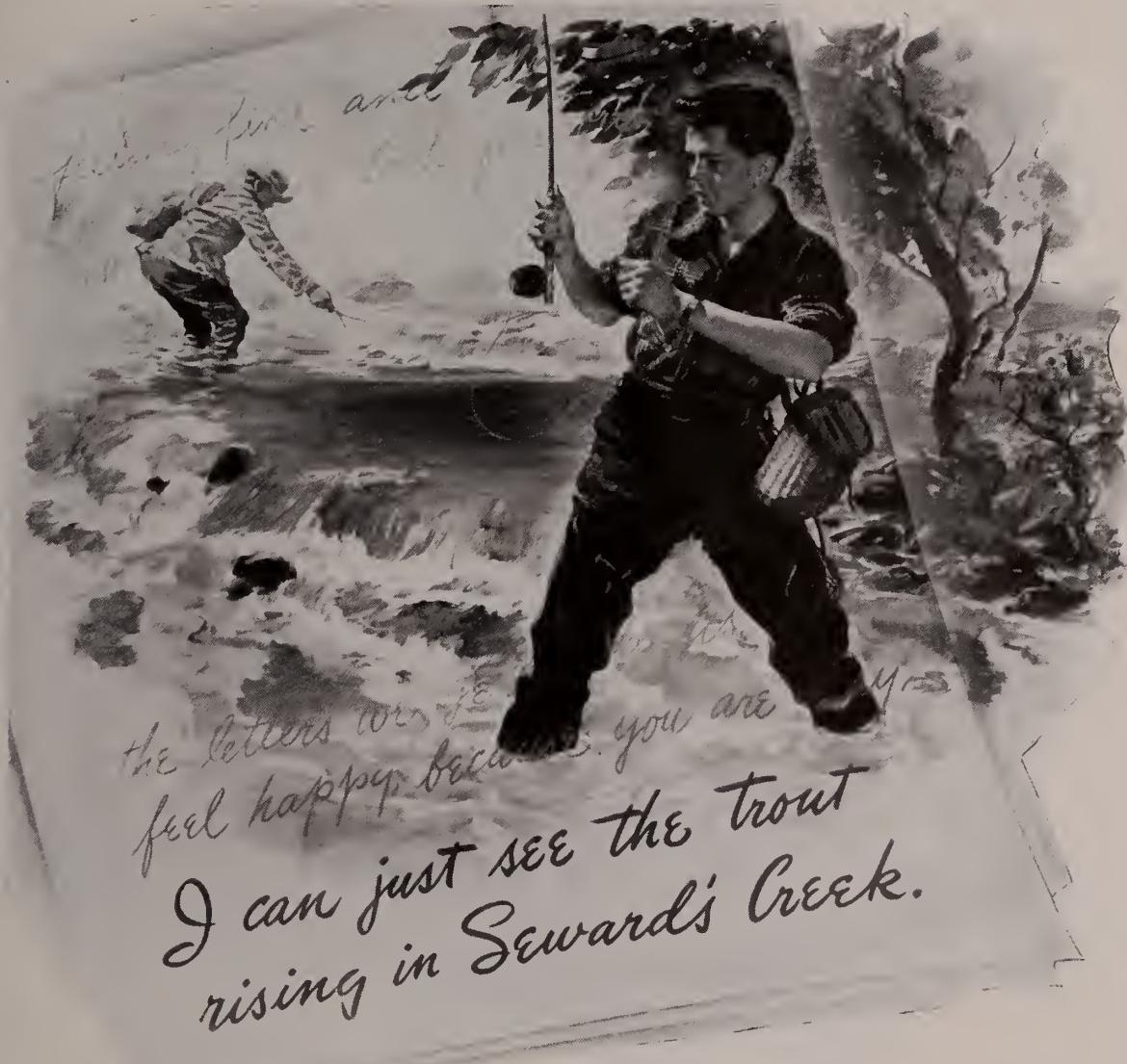
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*A glass of beer or ale—not of crucial importance, surely . . . yet it is little things like this that help mean home to all of us, that do so much to build morale—ours and his.*

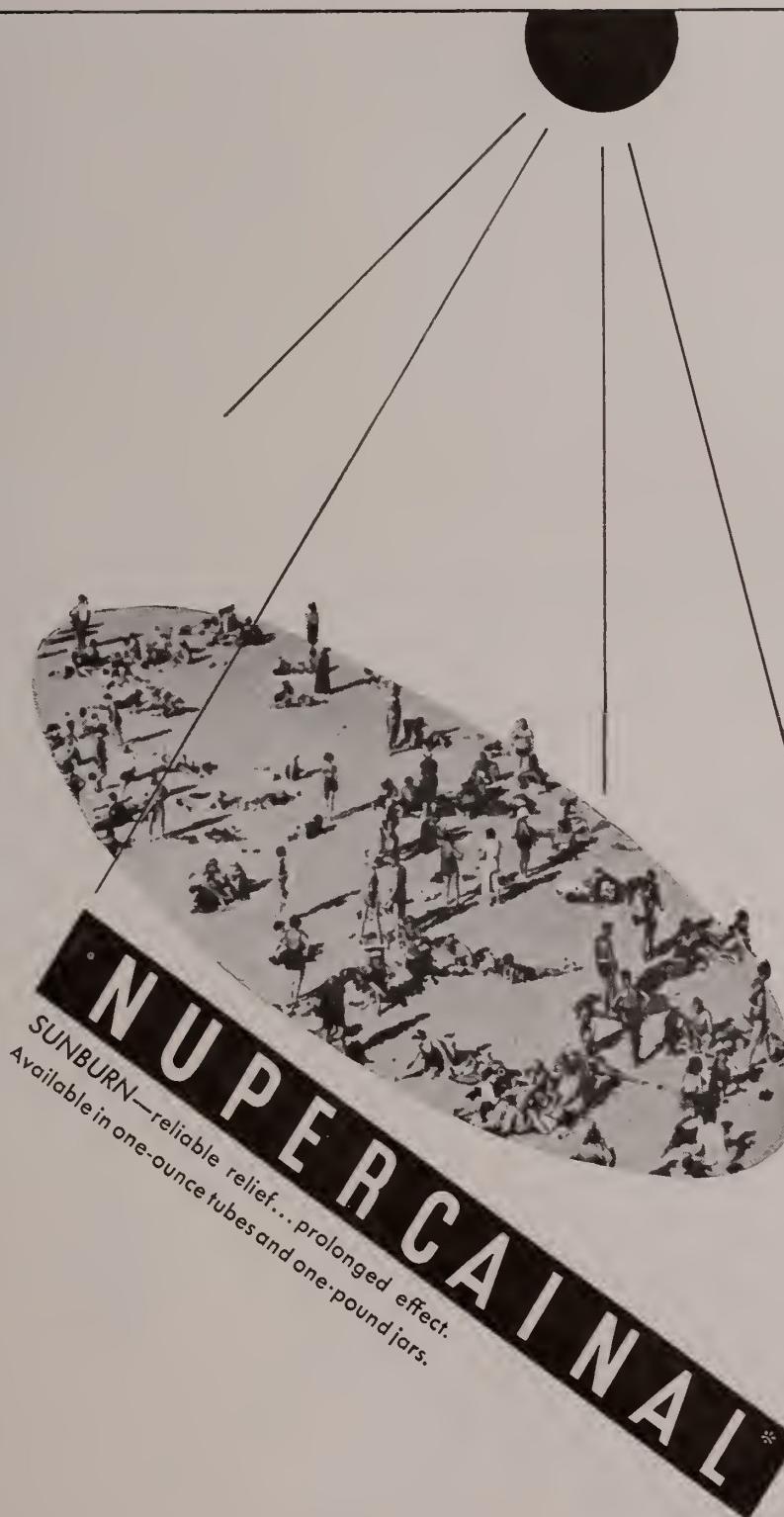
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presented to the base at Jacksonville Beach were read. A collection was taken at this time to enable Mrs. Henley to continue her worthwhile defense activities.

Mrs. Hayes announced the date of the Annual Meeting of the State Auxiliary to be held in St. Petersburg, April 14. Delegates elected to the convention were Mrs. Gordon H. Ira and Mrs. S. M. Copeland; alternates, Mrs. Frank Wilson and Mrs. Charles Henley.

Appointed to serve on the nominating committee were Mrs. Raymond H. King, chairman, Mrs. B. A. Chapman, and Mrs. Edward Jelks. This committee will submit its report at the June meeting, to be held at the home of Mrs. Jelks, 2244 St. Johns Avenue, at which time officers for the new year will be elected.

At the close of the meeting, guests were invited into the dining room where a delightful social hour was enjoyed.

### ADVERTISERS' NOTES

#### SHIPPING ADDRESS FOR YOUR ART EXHIBIT

Artist-physicians desiring to exhibit their works at the June A.M.A. Meeting should ship their works not later than May 20 to the following address:

American Physicians Art Association, Room 1302, 308 W. Washington St., Chicago, Ill. Pack carefully and ship by express collect, including \$50 insurance.

Mead Johnson & Company have offered to pay the express charges both ways (including insurance up to \$50).

Art objects exhibited are automatically eligible for inclusion in the next Parergon, as well as for one of the numerous A.P.A. Ass'n prizes.

Further information may be obtained from Francis H. Redewill, M.D., Secretary, American Physicians Art Association, Flood Bldg., San Francisco, Calif.



#### CONTROL OF RADIO TRANSMISSION

Tiny pieces of crystal made to police radio waves are playing an important part in directing battle maneuvers of American ships, tanks, planes and submarines.

Millions of these thin, wafer-like quartz crystals, scientifically cut according to a principle discovered by Dr. E. D. Tillyer, American Optical Company's research director, were produced in 1943 by radio manufacturers and employed in transmitters to send messages without fear of discovery by the enemy.

The crystals, described by the scientist as the "heart of a radio transmission system," control the frequency or wave length of messages sent out over the airways. The enemy is prevented from intercepting the messages by a method of operating the crystals considered a secret by the Navy.

Concern over inefficient crystals produced by a previous cutting method led to the discovery of Dr. Tillyer's new technic. By cutting the crystals with one face parallel to an electrical axis of the mother crystal, a technic exactly opposite from the previous method, he was able to produce crystals which control radio transmission with greater efficiency and constancy.

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**MEDICINE**—Two Weeks Intensive course Internal Medicine starts June 19. Two Weeks Course in Gastro-Enterology starts June 5.

**GYNECOLOGY**—Two Weeks Intensive Course starting October 2. One Week Personal course Vaginal Approach to Pelvic Surgery starts June 5.

**OBSTETRICS**—Two Weeks Intensive Course starts June 26.

**ANESTHESIA**—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

**GASTROSCOPY**—Personal Course starts June 19 and October 16.

**OTOLARYNGOLOGY** — Two Weeks Intensive Course starts October 2.

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Now less than six months since first copies were seen, the Bausch & Lomb book "The Human Eye in Anatomical Transparencies" has already taken its place among the classics of scientific literature, eloquently justifying the tremendous amount of original research and expense that went into its production.

Convinced that true professional and ethical concepts are rooted in skills based on knowledge, Bausch & Lomb has recognized its responsibility to add where possible to the opportunity for acquisition of professional knowledge. Publication of the Human Eye book is one of the company's most noteworthy efforts in that direction. Evidence of the interest is the fact that its initial edition of 10,000 copies was sold within the first month. The second edition is now being printed.

In addition to its obvious value as a professional reference, the book has been hailed as an extraordinarily useful teaching aid. Further to implement this usefulness, Kodachrome slides of the McHugh anatomical paintings are now available. Thirty-four to a set, the slides reproduce composite layers of the eye as they appear in the serial transparent views in the book. An accompanying reference manual provides a description and a key to anatomical details shown in each slide.

Every effort has been expended to make these Kodachrome reproductions duplicate the color values and anatomical details of the artist's original paintings. Each slide reproduces the composite layers of the eye as found in a serial dissection and as they appear in the transparent acetate section of the book. The results are truly a miracle of artistic perfection and technical accuracy.

## BORDEN AWARDS

Thirty-six American scientists have thus far been honored with Borden Awards, each of \$1,000 and a gold medal, according to a new directory of recipients. Established in 1936 by the Borden Company to recognize meritorious work and encourage new research, the awards are administered by five leading organizations: The American Chemical Society, American Dairy Science Association, American Home Economics Association, American Institute of Nutrition, and the Poultry Science Association.

## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

HANDBOOK OF NUTRITION. A symposium prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association. The book embraces in its authorship most of the leading authorities on nutrition in the United States. It provides the latest literature on proteins, carbohydrates, fats, mineral salts and vitamins. Cloth. Price, \$2.50. Pp. 586, with illustrations. Chicago: American Medical Association, 1943.

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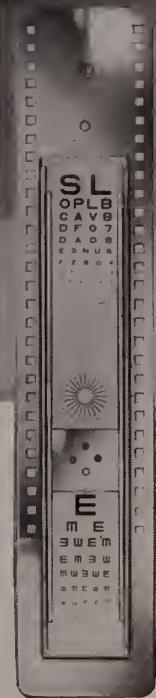
R-5

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## SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association .....	John R. Boling, Tampa.....	Robert B. McIver, Jacksonville .....	
Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville....	" " "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach...	" " "	Miami, Postponed
American Medical Association .....	James E. Paullin, Atlanta, Ga.....	Olin West, Chicago .....	Chicago, June 12-16, 1944
Southern Medical Association .....	W. T. Woottton, Hot Spgs., Ark.....	Mr. C. P. Loranz, Birmingham .....	November, 1944
Alabama Medical Association .....	H. B. Searcy, Tuscaloosa .....	D. L. Cannon, Montgomery .....	Montgomery, Apr. 18-20, 1944
Georgia, Medical Assn. of .....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta .....	Savannah, May 9-12, 1944
Florida—			
Section, Am. College Phys.....	R. H. Knowlton, St. Petersburg .....	Kenneth Phillips, Miami .....	Gainesville, June 8, 1944
Basic Science Exam. Board .....	M. W. Emmel, D.V.M., Gainesville	J. F. Conn, Ph.D., DeLand .....	
Dental Society, State .....	E. C. Lunsford, D.D.S., Miami .....	H. L. Cartee, D.D.S., Miami .....	
Derm. and Syph., Soc. of .....	J. Frank Wilson, Jacksonville.....	Wesley W. Wilson, Tampa .....	
East Coast Medical Association .....	T. C. Kenaston, Cocoa .....	I. M. Hay, Melbourne .....	
Hospital Association .....	Mr. W. E. Arnold, Jacksonville .....	Miss Katharine Moyer, Lake Wales .....	
Industrial Surgeons, Assn. of .....	Frank D. Gray, Orlando .....	A. M. Bidwell, Tampa .....	
Medical Examining Board .....	George S. McClellan, Pompano .....	W. M. Rowlett, Tampa .....	
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville .....	Chairman .....	Jacksonville, June 26, 27, 1944
Nurses Association, State .....	Miss Florence Jones, Jacksonville .....	Miss Madalee Hazel, Limona .....	Jacksonville, June 19-24, 1944
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville .....	C. E. Dunaway, Miami .....	
Pathological Society .....	L. Y. Dyrenforth, Jacksonville .....	Iva C. Youmans, Miami .....	
Pediatric Society .....	Ludo von Meyenbug, Daytona B.	Robert Blessing, Ft. Lauderdale .....	To Be Announced
Pharmaceutical Association, State .....	Mr. H. B. Douglas, Bonifay .....	Mr. R. Q. Richards, Ft. Myers .....	Miami, To Be Announced
Public Health Association .....	A. P. Black, Gainesville .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	Walter A. Weed, Orlando .....	Chas. M. Gray, Tampa .....	
Railway Surgeons' Association .....	Frank D. Gray, Orlando .....	W. C. Page, Cocoa .....	
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales .....	Mrs. May Pynchon, Jacksonville .....	
Chattahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine .....	Robert B. McIver, Jacksonville .....	
Gulf Coast Clinical Society .....	G. G. Oswalt, Mobile, Ala. ....	C. L. Rutherford, Mobile, Ala. ....	
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola.....	Kenneth Phillips, Miami .....	
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta .....	
Suwannee River Medical Society .....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City .....	

**COMPONENT SOCIETIES BY MEDICAL DISTRICTS**

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Don S. Fraser, M.D. 456 Grace Ave. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		14	100%	
Escambia *Santa Rosa	J. K. Turberville, M.D. Century	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	47	43	A-1-45 C. D. Whitaker, M.D. Marianna
Franklin-Gulf	T. A. Meriwether, M.D. Wewahitchka	J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	6	100%	
Jackson *Calhoun	C. D. Whitaker, M.D. Burton Bld., Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	100%	
Walton-Okalosa	E. L. Huggins, M.D. DeFuniak Springs	A. G. Williams, M.D. Lakewood	3rd Thursday 8:00 P.M.	6	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	100%	
Columbia *Baker, Hamilton	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	Thomas H. Bates, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	12	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	John L. Williams, M.D. Tallahassee	L. L. Dozier, M.D. Midyette-Moor Bldg. Tallahassee	Quarterly 8:00 P.M.	39	38	A-2-44 William D. Rogers, M.D. Chattahoochee
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		9	100%	
Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	C. A. O'Quinn, M.D. Perry	Last Friday 8:00 P.M.	4	100%	
Alachua *Bradford, Gilchrist, Union	W. E. Murphree, M.D. 1270 Seminole Ave. Gainesville	J. H. Thomas, M.D. 749 E. Main St. N. Gainesville	2nd Wednesday 7:30 P.M.	28	25	
Duval *Clay	J. G. Lyerly, M.D. 514 Greenleaf Bldg. Jacksonville 2	O. E. Harrell, M.D. 712 Laura St. Jacksonville 2	1st Tuesday 8:15 P.M.	197	196	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
Marion *Levy	Robbins Nettles, M.D. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	26	100%	
Nassau	W. A. Brewster, M.D. Callahan	Geo. A. Dame, M.D. Fernandina	2nd Wednesday 8:00 P.M.	7	6	
Putnam	Bernard E. Kane, M.D. Crescent City	Edward W. Ford, M.D. Crescent City	2nd Tuesday Even Months 7:00 P.M.	9	100%	
St. Johns	G. Walter Potter, M.D. East Coast Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	I. F. Bean, M.D. Melbourne	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	9	
Lake *Sumter	H. S. Cherry, M.D. Center Hill	R. H. Williams, M.D. Eustis	1st Thursday 12:30 P.M.	18	17	B-4-44 D. T. McEwan, M.D. Orlando
Orange *Osceola	Duncan McEwan, M.D. 106 E. Central Ave. Orlando	Albert C. Kirk, M.D. 823 E. Colonial Dr. Orlando	3rd Wednesday 8:00 P.M.	95	92	
Seminole	Samuel Puleston, M.D. Brumley-Puleston Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	13	100%	
Volusia *Flagler	T. H. Dillard, M.D. DeLand	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	43	39	
Hillsborough	R. S. Torbett, M.D. 814 First Nat. Bk. Bldg. Tampa 2	Charles M. Gray, M.D. 306 Citizens Bldg. Tampa 2	1st Tuesday 8:00 P.M.	107	101	
Manatee	S. G. Hollingsworth, M.D. Professional Bldg. Bradenton	L. W. Blake, M.D. Bradenton	3rd Tuesday 7:00 P.M.	12	100%	C-5-44 Leland F. Carlton, M.D. Tampa
Pasco-Hernando- Citrus	S. C. Harvard, M.D. Brooksville	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P.M.	11	100%	
Pinellas	J. A. Hardenbergh, M.D. 404 Power & Light Bldg. St. Petersburg 5	W. C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg 4	1st and 3rd Fridays 6:30 P.M.	108	100%	
Sarasota	O. H. Cribbins, M.D. 138 N. Link Sarasota	J. E. Harris, M.D. 224 Commercial Court Sarasota	2nd Tuesday 8:30 P.M.	18	100%	
DeSoto-Hardee- Highlands- Charlotte-Glades	M. C. Kayton, M.D. Wauchula	C. H. Kirkpatrick, M.D. Box 454 Arcadia	Quarterly	20	100%	
Lee *Collier, Hendry	M. F. Johnson, M.D. Box 1266 Fort Myers	W. A. Harrison, M.D. 1029 First St. Fort Myers	3rd Tuesday 7:30 P.M.	17	100%	C-6-45 Edgar Watson, M.D. Lakeland
Polk	W. F. Peacock, M.D. Barnett Embry Bldg. Bartow	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	61	54	
Palm Beach	J. L. Carlisle, M.D. 301 Guaranty Bldg. W. Palm Beach	E. W. Stephens, M.D. 910 Harvey Bldg. W. Palm Beach	4th Monday 8:00 P.M.	65	100%	D-7-45 William Y. Sayad, M.D. West Palm Beach
St. Lucie- Okeechobee-Indian River-Martin	M. D. Council, M.D. Box 607 Ft. Pierce	Adrian M. Sample, M.D. Box 176 Ft. Pierce	3rd Thursday 8:00 P.M.	17	100%	
Broward	J. A. Johnston, M.D. 222½ S. Andrews Ave. Ft. Lauderdale	O. C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	2nd Tuesday 8:00 P.M.	41	100%	
Dade	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami, 32	J. J. Nugent, M.D. 701 Huntington Bldg. Miami, 32	1st Tuesday 8:30 P.M.	350	337	D-8-44 Elbert McLaury, M.D. Hollywood
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	Julio J. DePoo, M.D. 419 Eaton St., Key West	1st Sunday 9:00 P.M.	5	2	

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# The JOURNAL *of the* Florida Medical Association, Inc.

Vol. XXX

JUNE, 1944

No. 12

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Old people who eat little and lead quiet, inactive lives tend to become constipated. Restoration and maintenance of "habit time" is of prime importance to the patient's well-being.

Petrogalar gently, persistently, *safely* helps to establish "habit time" for bowel movement. It is evenly disseminated throughout the bowel, effectively penetrating and softening hard, dry feces, resulting in comfortable elimination with no straining . . . no discomfort. Petrogalar to be taken only as directed.

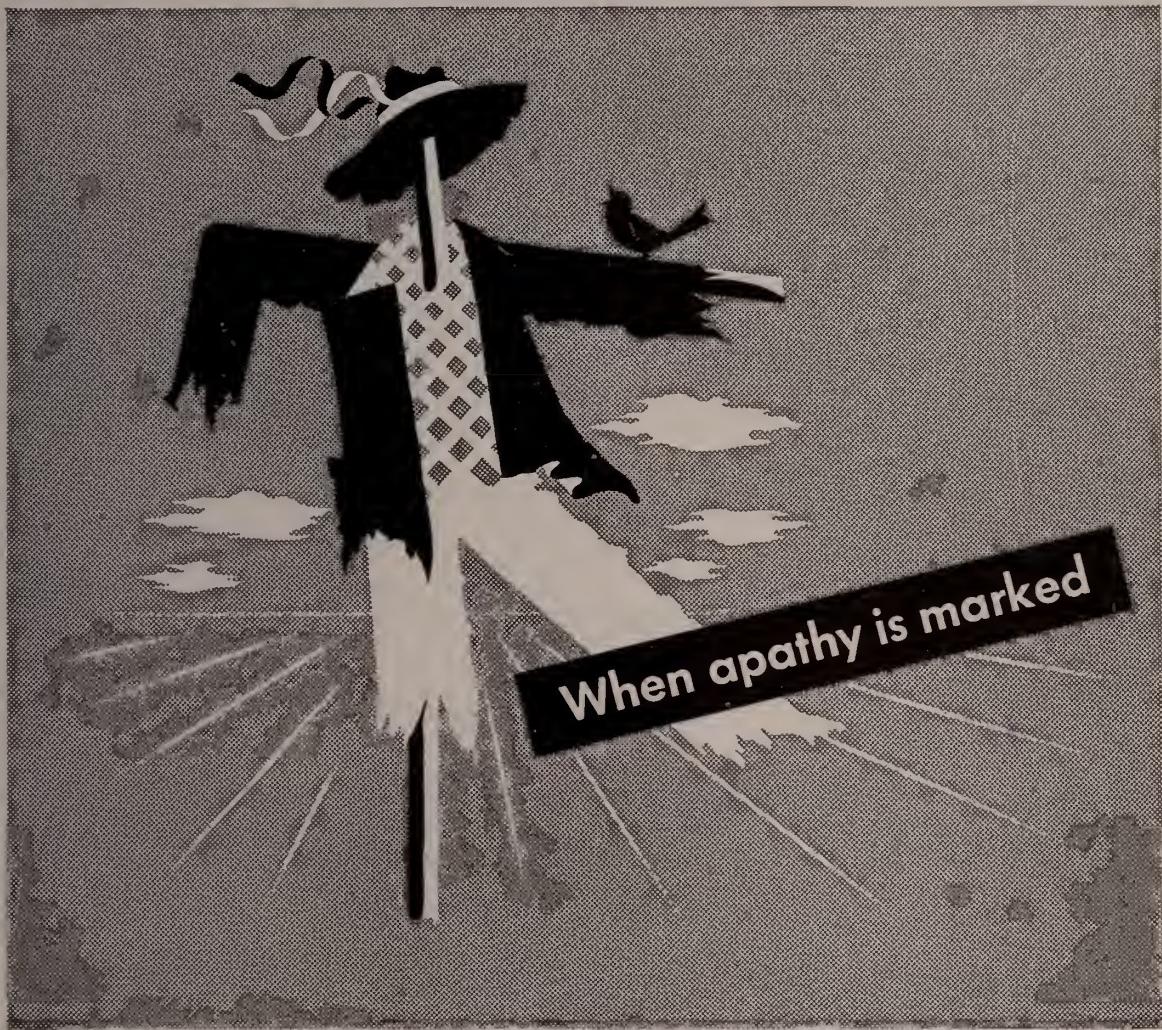
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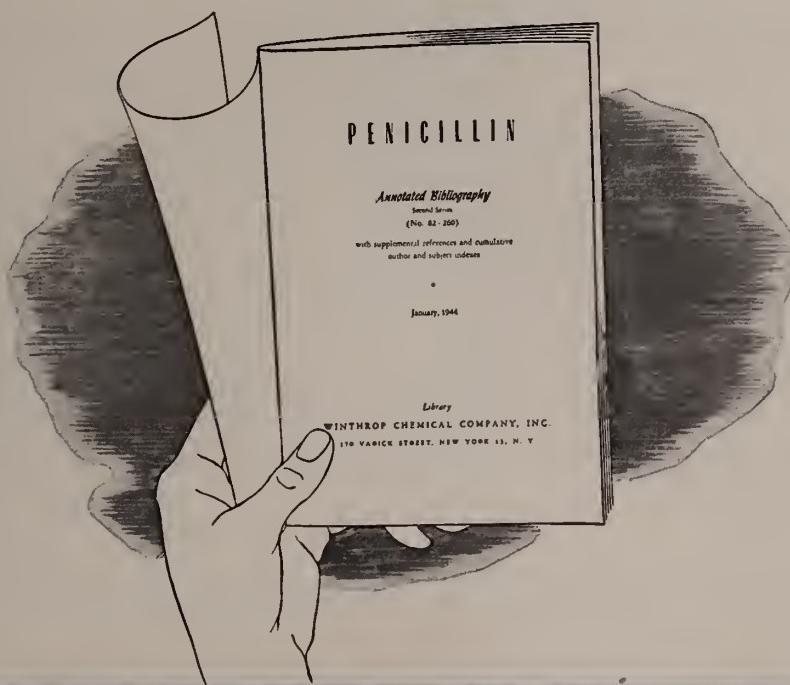
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New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410.  
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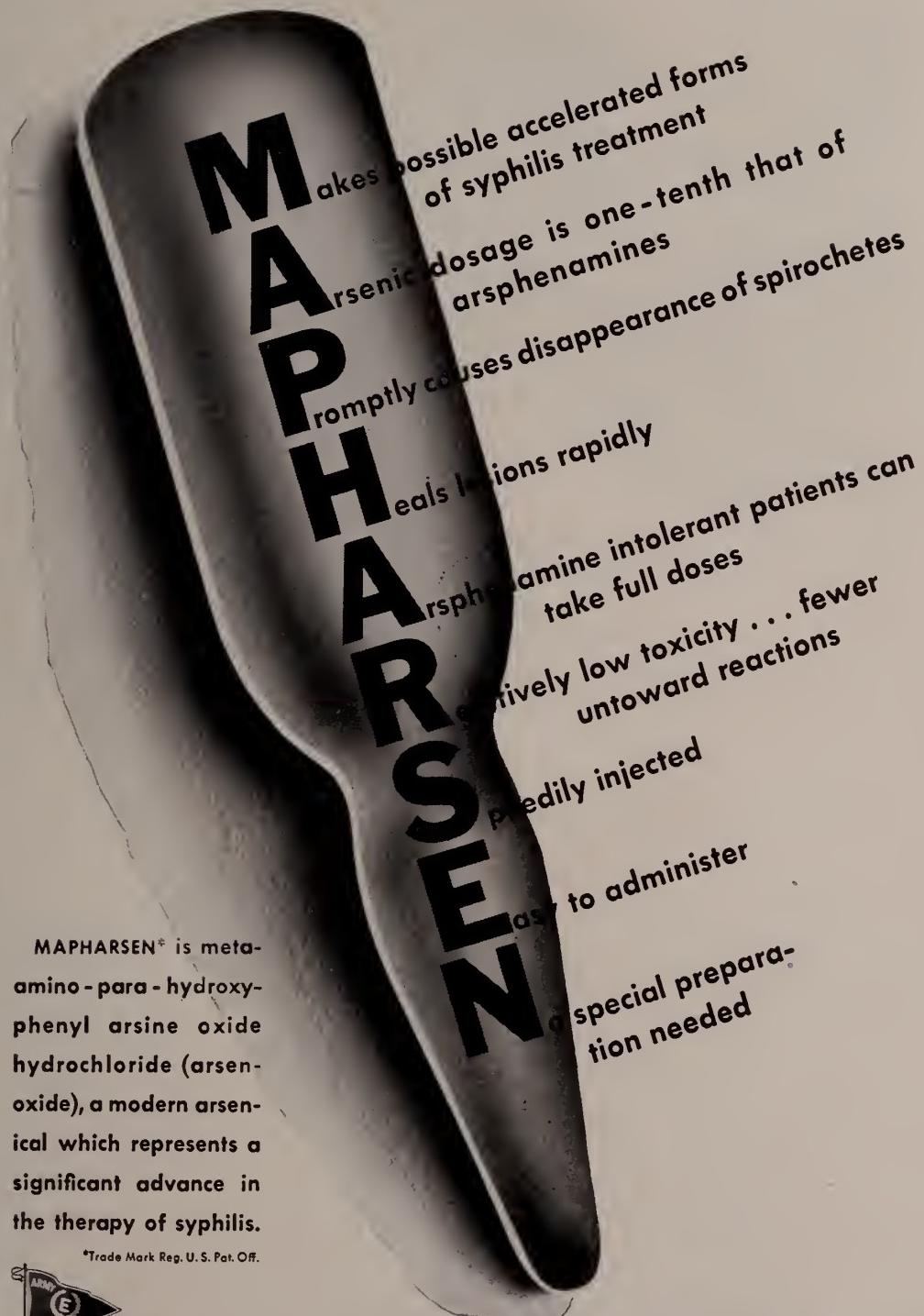


Literature on request

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(1) Am. J. Obst. & Gyn., 35:839, 1938. (2)  
West. J. Surg., Obst. & Gyn., 51:150, 1943. (3)  
Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec.,  
155:316, 1942.

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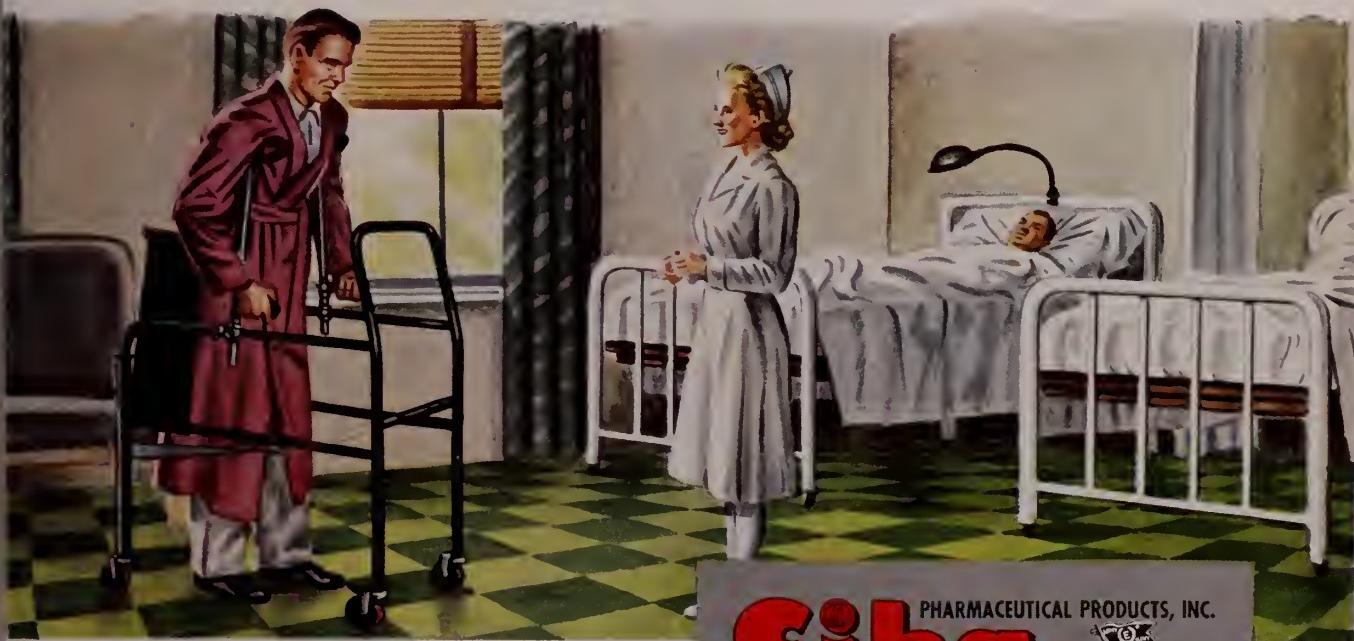
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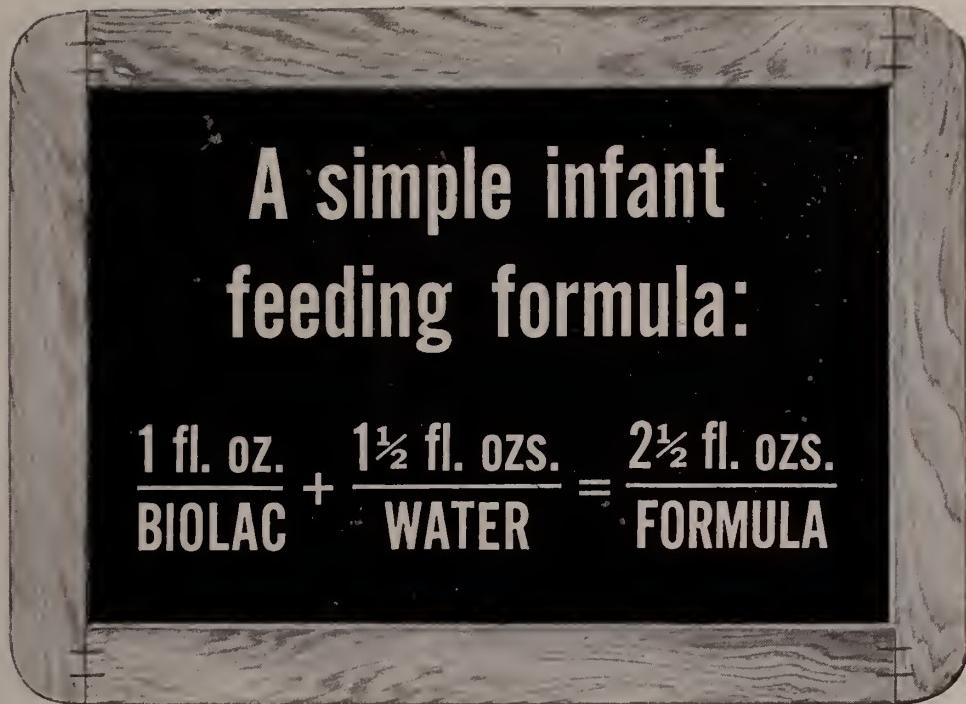
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# Estrogenic Hormones

It was only a few years ago that medical writers were inclined to question the potency and therapeutic efficacy of estrogenic substances. Today, with well defined standards of activity, and with preparations of a purity and activity unheard of less than two decades ago, estrogenic hormones have a well established place in medical practice.

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<sup>1</sup>Jl. Clin. Endocrinology 3:648, Dec. 1943.

For literature write the Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

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Three daily servings (1½ oz.) of Ovaltine provide:

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PROTEIN . . . . .	6.0 Gm.	31.2 Gm.	VITAMIN A . . . . .	1500 I.U.
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IRON . . . . .	10.5 mg.	11.94 mg.	COPPER . . . . .	.5 mg.

\*Each serving made with 8 oz. of milk; based on average reported values for milk.



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'Dexin' helps assure uncomplicated digestion and assimilation. Its high dextrin content promotes the formation of soft, flocculent, easily digested curds. Distention, colic and diarrhea are avoided because of the relatively non-fermentable form of carbohydrate. 'Dexin' is readily soluble in hot or cold milk.

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COMPOSITION	Dextrins . . . . .	75%	Mineral Ash . .	0.25%
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Available carbohydrate 99%      115 calories per ounce  
6 level packed tablespoonfuls equal 1 ounce



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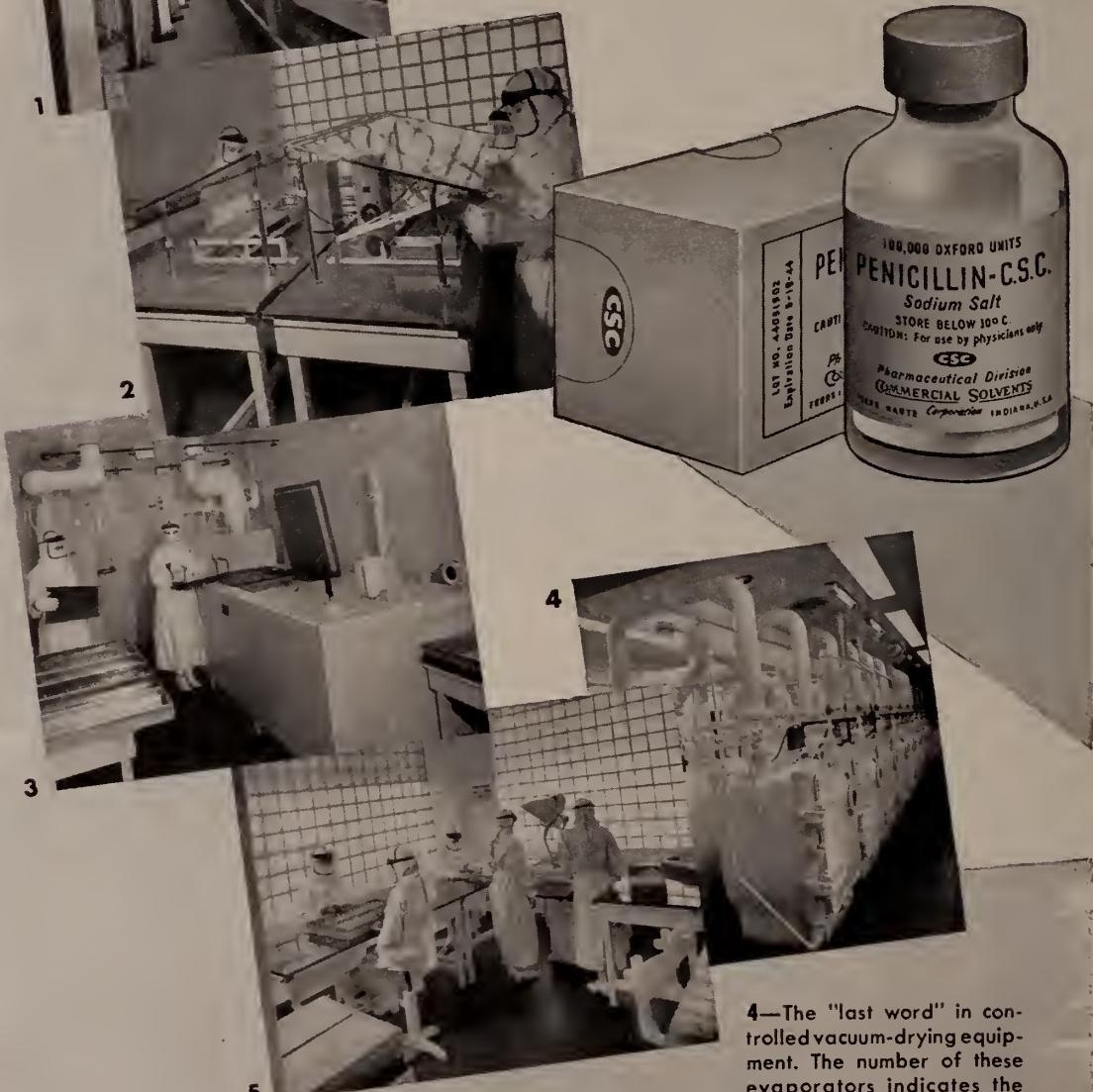
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1—Instead of the two-liter flasks in which penicillin ordinarily is made by "surface culture," Penicillin-C.S.C. is made in a battery of giant tanks, each of 12,000 gallon capacity, by "submerged culture," an operation of vastly increased sensitivity, calling for the utmost in care and control.

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facial shields which carry the technician's breath away from the work area—

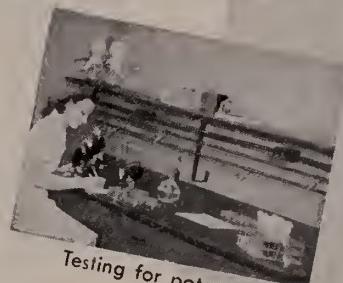
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Penicillin-C.S.C. will always be of dependable potency, sterility, and pyrogen-freedom—

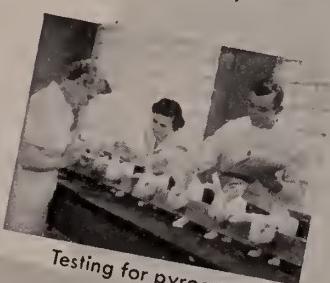
Penicillin-C.S.C., now allocated as the armed forces direct, will be available in adequate distribution throughout the country as soon as released.



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Testing for pyrogens

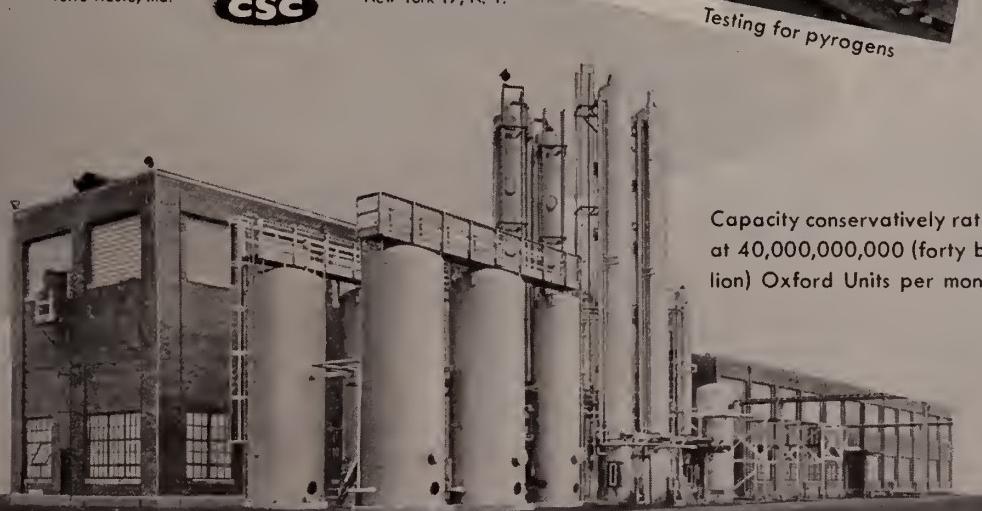
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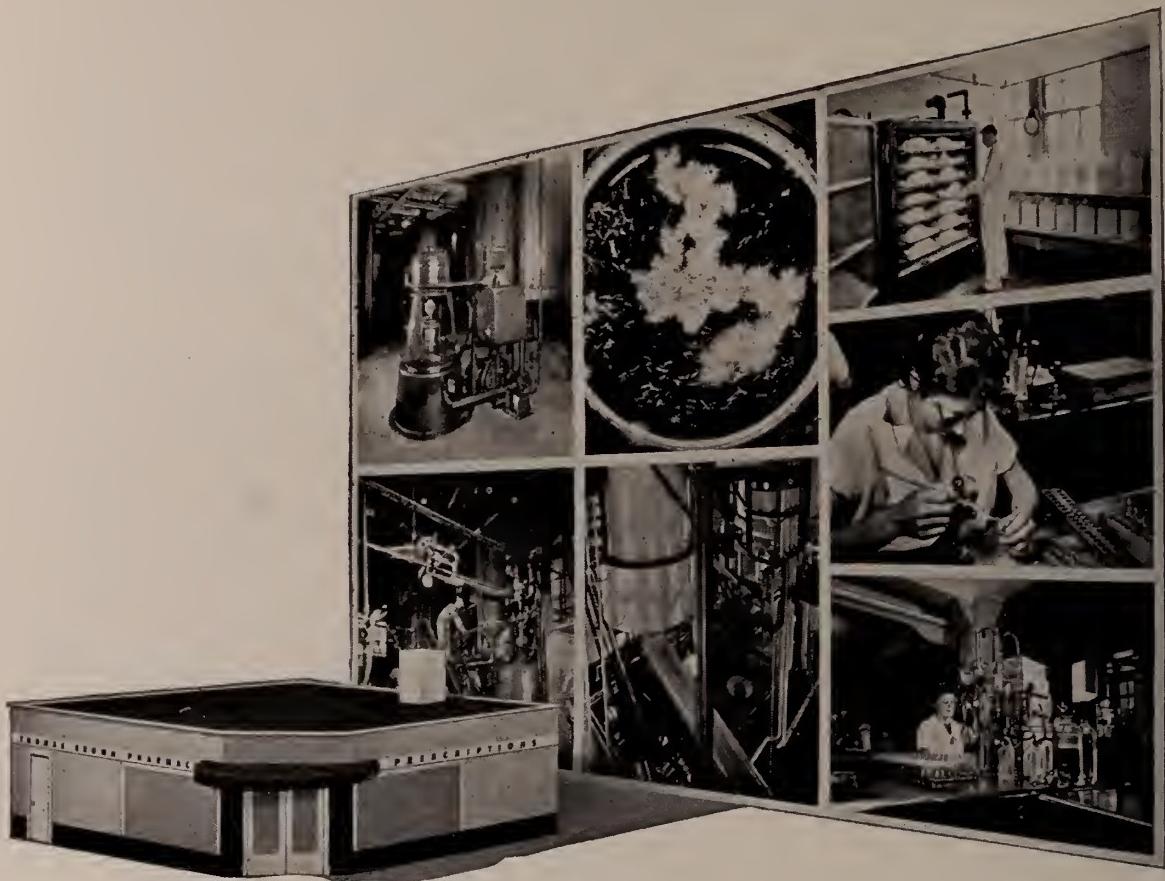
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XXX

Jacksonville, Florida, June, 1944

No. 12

## PRESIDENT'S ADDRESS

EUGENE G. PEEK, M. D.  
OCALA

With the beginning of this Convention year, it was obvious that during its course the Florida Medical Association should experience many difficulties and face many problems. It was even freely predicted that it might well succumb, at least in part, to the unusual circumstances which the war and the war effort necessarily created. I recall receiving numbers of expressions of condolence and sympathetic understanding, even at the outset of my period of service.

Certainly problems have come—some of them beyond the capacity to anticipate and some beyond the ability fully to overcome. Nevertheless, the Association has carried on its essential activities with a measure of confidence, and perhaps not without some measure of accomplishment. Regret that a more active and aggressive program could not be carried out is mingled with gratification over the year's cooperative effort put forth by the officers and members in coping with the present emergency. These sentiments are crowned with confidence in the ability of the Association to meet with concerted endeavor and unflagging zeal whatever extraordinary demands the future may hold.

We cannot be too keenly aware of the inroads that are being made upon the legitimate field of practice of the medical profession in these days; nor can we in any measure afford to be indifferent to the prospects which appear on the horizon for more and more interference with the traditional trust of the profession. These trends should serve as a fair signal to us all and, indeed, a warning that even our very existence may be dependent upon our unity of purpose and effort.

To the members of the Association now in the armed services we as a body pay tribute in unstinted measure. On your behalf, and on mine, I desire to express here our warmest feelings of comradeship and professional fraternity toward them as well as our abiding interest in them, on whatever battlefield or other post of service they may be stationed. Not only are they soldiers fighting to preserve the ideals of the nation and

the profession dear to us all, but they are also our friends, our acquaintances, even our neighbors or associates perhaps. They are our colleagues, whose presence here today we miss and whose homecoming we earnestly anticipate, that we may welcome them again to our councils and to their individual fields of endeavor.

Likewise, I would pay homage to those of our membership who carry on valiantly on the home front. Amid the distractions of the present day, the weight of professional demands in civilian life has exacted an ever increasing expenditure of time and energy and strength. Yet, you who remain at home have not been unmindful that you, too, have a great duty to perform. You are performing it and will continue to perform it, keeping faith with the public to the limit of your ability and physical endurance. Also, inspired by the realization that you are literally the keepers of the Ark of the Covenant, on whose shoulders rests the responsibility of maintaining an active Association, you are marching resolutely forward to achieve the goals to which you, as members, dedicate your efforts.

Inevitably, this responsibility originates, as it should, with the individual members of the Association. However meticulous its construction, the superstructure of no organization can withstand the stress of functional strain without a sure foundation. I leave the high office you have bestowed upon me confident that we on the home front, if we so desire, can maintain this Association at a high level of efficiency throughout the period of the war, no matter how prolonged it may be. The individual membership need only lend its unfailing support, financial and otherwise.

It affords me genuine pleasure to commend the work of the regular committees, each under the leadership of an able chairman. The Committee on Legislation and Public Policy, with Dr. W. M. Rowlett as chairman, has made a notable contribution to the year's progress. At the request of Dr. Rowlett, Dr. Harold D. Van Schaick, his immediate predecessor, graciously consented to continue his activities through the session of the Legislature. To him the Associa-

tion owes a debt of gratitude for his untiring efforts, at great personal sacrifice, in effecting passage of Senate Bill No. 641, which became law on June 11, 1943. This amendment to section 458.06 of the Florida Statutes of 1941 provides that licenses to practice medicine in Florida must henceforth be registered within sixty days of the date shown on the license and that all unregistered licenses in effect on June 11, 1943, must be recorded within six months of that date. This measure strengthens the Medical Practice Act by correcting the serious omission in the original law of a time limit for registration of licenses and should thereby close the door to the use of fraudulent licenses.

Under the able and aggressive leadership of Dr. Edward Jelks, the Committee on War Participation, which includes the Medical Procurement and Assignment Service, has labored diligently and with remarkable effectiveness. The careful study made of the state and the justice to the state as a whole in the equitable distribution of physicians are praiseworthy accomplishments. Even more commendatory perhaps is the procurement of 675 physicians for military service, an attainment which enables the Association to take pride in the fact that the quota for Florida has always been met, or exceeded, in all calls made. I trust that after the war this committee, with strategic representation throughout the state, will continue to function for this organization in the task of relocating physicians. It is as much a duty and a privilege to assist in the relocation of returning colleagues and the placing of new ones entering practice as to foster enlistment in the armed forces. As with the present period of transition, the period of reorientation will not be without its difficulties.

All of the formalities prerequisite to putting into effect in Florida the plan for the temporary licensing of relocated physicians for the period of the war emergency have now been completed. Drafted under the statutory emergency powers of the State Defense Council, this plan is designed to meet emergency needs during the war. Dr. Leigh F. Robinson renders valuable service as chairman of the Division of Health and Housing of the State Defense Council of Florida, succeeding Dr. Gilbert S. Osincup, immediate past president of the Association, who was called to active duty in the U. S. Public Health Service. Dr. Robinson has also served the Association this year as chairman of the Committee on Public Relations. Serving in this dual capacity and

aided by the members of his committee, he has been largely instrumental in making effective the plan for temporary licensing of relocated physicians, as his detailed report will show.

In brief, the procedure is accomplished by an Executive Order from the Governor directing the State Defense Council to license during the war emergency relocated physicians in particular counties. The Council must, however, first receive a certificate of need for such a physician from the County Medical Society, or from the Board of Governors of the Association in the absence of a County Medical Society. This certificate must contain the name of the physician and of the state in which he last practiced, and statements to the effect that he was in good standing in that state and that his educational qualifications meet the requirements of this state.

This certificate must be approved by the State Office of Medical Procurement and Assignment Service. It must also be accompanied by a certificate from the State Board of Medical Examiners, a certificate from the State Board of Health and a resolution from the Board of Governors of the Association, all three approving the procedure for temporary licensing of relocated physicians. In addition, accompanying the certificate of need there must also be a resolution of the State Defense Council issuing the license to the physician certified to practice in a particular county only, subject to the same laws and regulations as other physicians. This resolution contains the provisions that his license is subject to revocation by operation of law or by direction of the Governor and that the license shall in no event continue in effect longer than six months after the end of World War II.

The very creditable accomplishments of the past decade have continued on the same high level during the year now closing by the Committee on Medical Postgraduate Course under the direction of the chairman, Dr. Turner Z. Cason. The graduate courses were originally designed primarily for the benefit of the general practitioner in the field, who rarely, if ever, is able to go to the larger centers for graduate work, and this purpose may well be kept foremost as the curriculum expands and the program broadens. It is noteworthy that the attendance at the eleventh annual graduate short course last June was the second largest on record, a registration that would be gratifying in normal times.

The Committee on Cancer Control, under the able leadership of its chairman, Dr. John N. Moore, has been particularly active throughout the year. A careful survey of the state has been made, and there has been a special effort to co-operate with the national organizations engaged in the control of cancer. This has been one of the neglected fields in Florida. I hope that in the near future it may be possible to obtain from the Legislature an adequate appropriation for the establishment of a state clinic for indigent persons afflicted with this disease.

As chairman of the Committee on Medical Economics, Dr. Harrison A. Walker had devoted a great deal of time to its work, and his resignation was accepted with genuine regret. Fortunately, it was possible to secure Dr. Ferdinand A. Vogt as his successor, and under his direction the well laid plans of Dr. Walker have been carried out. The committee has been able to have several meetings and has been successful in establishing a better foundation for the stabilization of fees for industrial surgery, as Dr. Vogt's report will show.

The Committee on Venereal Disease Control has been especially active. The chairman, Dr. Elijah T. Sellers, and the members of the committee have cooperated with the State Board of Health in complying with the recent acts of the Legislature, which make treatment for venereal diseases compulsory, and in establishing various hospitals in the state for the purpose of treating these diseases. It would appear that we are beginning to see light in the control of these social menaces.

The Committee on Tuberculosis and Public Health, of which Dr. William C. Blake is chairman, is always active. Progress has been made this year in committing the public school system of the state to the principle of roentgen examination of its teaching staff, and it is hoped that the practice of this protective measure may become mandatory.

In view of the large number of physicians in the military services and the difficulty of getting speakers from either military or civilian life, we are particularly indebted to the Committee on Scientific Work for the excellent program arranged for this meeting. Without the experienced leadership of Dr. Herbert E. White, the chairman of this committee, we should doubtless not be so fortunate as we are in the opportunities afforded us here.

The Committee on Maternal Welfare, of

which Dr. William C. Thomas is chairman, and the Committee on Child Health, with Dr. George L. Cook as chairman, have been active in matters of maternal and pediatric care. They deserve commendation as do the several other committees and their respective leaders, too numerous to mention specifically in the allotted time, for the contributions they have made to the year's work. Personally, I desire to express my appreciation of their cooperative endeavor, and in the name of the Association also, I thank them.

The Board of Governors has been untiring in its efforts to further the interests of the Association throughout the year, and its members have been especially considerate in the number of meetings they have attended in these busy times. Without their cooperation the year's work would indeed be a failure. Dr. Robert D. Ferguson, the chairman, will present a full report of the activities of this board.

To Dr. Stewart G. Thompson I am deeply obligated for his tactful and invaluable assistance to me as president. He conducts the business of the Association in an admirable manner, and this organization is to be congratulated on having a managing director highly efficient and tireless in his labors on its behalf.

Because of the war effort it was considered inexpedient to have the customary preconvention meeting this year. The reports of the councilors, usually read at this meeting, will be published in the Journal, as was done last year. The Board of Governors also deemed it wise to cancel the district meetings again this year and to streamline the program for the annual convention because of war time considerations.

I regret that as president I have been unable, because of transportation difficulties and the pressure of business, to travel over the state as I should like to have done. I am pleased to report, however, that I have been able to meet every call made upon me to speak, to attend a committee meeting, or to go in the interest of the Association.

It is my observation that the time has come when the medical profession must become more politically minded if it wishes to put up adequate defense against the encroachments steadily being made upon it. Successful preservation of worthy ideals and practices comes only at a price, and one that dare not be withheld too long, whatever the cost.

Too, the public should be apprised more fully of what the profession has made available

for its protection in the control of diseases and in emergency service. Greater activity on the part of the profession in disseminating this information would be helpful. Certainly broader education in these matters should promote better understanding and greater cooperation generally between the public and the profession.

It is my conviction also that some form of group insurance for hospitalization should be agreed upon that would be acceptable to the Association. If we do not adopt a suitable plan, one not of our choosing and with features we should doubtless deplore is likely to be forced upon us.

As I retire from the office of president, I sincerely thank the members of the Association for the honor they have bestowed upon me and for the privilege I have had in serving them during the year now closing. Also, I am grateful to the officers who have served with me for their fine cooperation. I only wish, as I am sure they do, that the times had permitted the opportunity for doing a more constructive piece of work. May the victory now assured come speedily, and with the peace a better day for this war-torn world, our valiant profession and the Association whose interests and welfare we cherish.

## PROCEEDINGS Seventy-First Annual Meeting *of the* FLORIDA MEDICAL ASSOCIATION HELD AT ST. PETERSBURG APRIL 13 and 14, 1944

### GENERAL SESSIONS

#### FIRST GENERAL SESSION

The Seventy-first Annual Meeting of the Florida Medical Association was called to order at 1:30 p.m., Thursday, April 13, in the Assembly Room of the Princess Martha Hotel, St. Petersburg, by President Eugene G. Peek.

Invocation by the Reverend E. A. Edwards, St. Peter's Episcopal Church, St. Petersburg.

Dr. J. A. Hardenbergh, president of the Pinellas County Medical Society, was introduced and gave the address of welcome.

Dr. Louie Limbaugh, first vice president, took the chair and called on Dr. Eugene G. Peek to deliver the presidential address. (See page 521).

Dr. Limbaugh relinquished the chair and turned the gavel over to President Peek.

The following report of the secretary-treasurer and editor of the Journal, Dr. Shaler Richardson, and managing director, Dr. Stewart G. Thompson, was read by Dr. Richardson:

#### REPORT OF SECRETARY-TREASURER-EDITOR, DR. SHALER RICHARDSON, AND MANAGING DIRECTOR, DR. STEWART THOMPSON

Mr. Chairman, Member of the Association and Guests:

It is my privilege to present the nineteenth annual report that Dr. Thompson and I have prepared. In spite of many difficulties that have arisen because of the war effort, the affairs of the Association have been carried on in a very satisfactory manner. In normal times the holding of district medical meetings in the fall of the year was considered a valuable and important function of the Association. During the last two years the district medical meetings were not held for reasons that are obvious: the shortage of doctors caused by approximately 30 per cent of our membership entering military service, restricted travel and hotel accommodations, and the many new activities necessitated by the war effort. As an example, committees on procurement and assignment of the state and county societies have spent a great deal of time and study in the effort to furnish Florida's full quota of doctors for military service. The activities of our loyal leaders in this field have kept Florida at the top with a full quota.

A plan for the temporary licensing in Florida of re-located physicians for the war emergency was put into effect this year. The temporary licenses in no event shall continue in effect longer than six months after the end of World War II. The plan was drafted under the statutory emergency powers of the State Defense Council to meet emergency needs during the war. Complete information including forms and blanks to be used was published in full in the March issue of your Journal.

The untiring efforts of the committee responsible for this important function certainly merit the unqualified commendation of every member of the Association.

The convention this year has been streamlined in an effort to cooperate in the war effort. The holding of an annual meeting, however, in the opinion of the members of the Board of Governors, is essential and will aid in the effort for victory by clarifying the doctors' part in contributing to the armed services, caring for the sick, and in the protection of public health.

#### MEMBERSHIP

The membership at the end of 1943 totaled 1,464, as compared with 1,461 for the previous year, an increase of 3. According to the latest reports from secretaries of county medical societies, there are 418 members with the armed services. There are 58 life and honorary members.

The By-Laws provide that members who have been on the official roster for 35 years shall become life members. During the past fiscal year seven regular members were advanced to life membership: John E. Maines, Sr., Lake Butler; Arthur R. Beyer, Tampa; Robert C. Black, Plant City; Lester J. Efird, Tampa; Rollin Jefferson, Tampa; Edward Smoak, Tampa; Henry C. Dozier, Ocala.

In the 1944 Florida Medical Directory which is now in press, symbols in the alphabetic list indicate members who are with the armed services; in the list of members by county medical societies honorary and life members are likewise designated.

#### 1944 MEDICAL DIRECTORY

The seventh annual Florida Medical Directory will soon be off the press. Each member is entitled to one copy free of charge. Additional copies are \$1.00 each.

The State Board of Health purchased 700 copies at a special rate of 50c each, to be mailed to doctors who registered but were not members of our Association.

Two thousand copies of the Medical Directory have been ordered at a printing cost of \$359.95. The income from advertising and sale of Directories totaled \$620.00. The value of the Medical Directory is again emphasized by the number of copies requested by those interested in the problem of medical care. The need for this Directory has been so widely demonstrated that it was deemed advisable and necessary to have the 1944 edition published.

#### GROUP LIABILITY INSURANCE

Several of our members who hold physician's and surgeon's liability certificates with the Aetna Casualty and Surety Company under our group policy have been led to believe that it is not possible to carry malpractice insurance with the Aetna after the expiration of their present certificates.

The group or master policy of our State Association with the Aetna is still in effect. It has not been canceled or withdrawn. The confusion was apparently caused in localities where local agents were changed. An editorial giving additional information is scheduled to appear in the May issue of your Journal.

#### MEDICOLEGAL ACTIVITIES

On previous occasions we have stated that it is not the function of the State Medical Association to file suit against persons who practice medicine in Florida in violation of the Medical Practice Act. The public health will be best protected when the practice of medicine is limited to those who are legally licensed and the members of our Association are, of course, interested in having violators brought to justice.

The State Board of Medical Examiners over a long period of years labored untiringly to rid the state of violators. During the last few years a helping hand has been extended by the State Board of Health through its Bureau of Narcotics. If there is an impostor or someone practicing medicine without a license in your district, contact Dr. Henry Hanson, State Health Officer, or Mr. M. H. Doss, Director of the Bureau of Narcotics of the State Board of Health at Jacksonville, in order that immediate investigation may be started.

Mr. Doss in his 1943 annual report to the State Health Officer submits some interesting data. The personnel of the Bureau of Narcotics includes five narcotic inspectors, three armed guards and one police officer assigned by the city of Jacksonville. Narcotic inspectors are stationed at Jacksonville, Miami, Pensacola and Tampa. A summary of the work done by these inspectors includes: number of arrests made for violation of the Medical Practice Act, 11; aggregate sentences imposed by the courts, 7 years, 9 months; aggregate fines imposed by the courts, \$293.08; cases pending in criminal courts, 2; defendants receiving a deferred or suspended sentence, 2; defendants placed on probation by the courts, 3; violations corrected where no legal action was taken, 56.

#### FINANCES

Receipts from all sources totaled \$19,096.15. Expenditures amounted to \$19,067.31, which leaves a balance of \$18.84. The meeting of expenses this year was made possible by cash donations for the purchase of war bonds in the amount of \$473.50, and by bonds donated having a cash value of \$55.50, making a total of \$518.00. Without the income from donations, there would have been a deficit of \$500.16 this year.

As of March 29 this year the membership totaled 1,443, of whom 1,353 have paid this year's dues, leaving 90 members from whom dues are collectible. The number of members exempt from the payment of dues totals 509, which represents \$5,090.00. In this group are 33 secretaries of county medical societies, 58 life and honorary members and 418 members in military service. The income during the past year was, of course, below normal, and every effort was put forth to keep expenses at a minimum.

Through special efforts, income has been increased on several items. Earnings from advertising totaled \$5,597.66. This is an increase of \$450.00 over last year. Subscriptions and miscellaneous sale of Journals and Directories totaled \$642.80; earnings from technical exhibits, \$1,620.00.

The books and records of the Association are open to our members and we will be glad to answer inquiries of any nature, as far as possible. The books have been audited by C. H. Goodrich, and a certification thereof is incorporated in the statements at the end of this report.

#### JOURNAL

There has been a dearth of scientific papers offered by our members for publication. The readers of the Journal have undoubtedly observed, however, that a number of excellent scientific papers have been received and published. At this time there are six papers scheduled for publication in the Journal. This is an excellent time to have good papers published promptly. The long delay in publication, experienced by authors in past years, was due to an over-supply of papers.

One new feature of the Journal was the enlargement of the abstract department. This change was explained in the January issue. In addition to abstracts of articles written by our own members and published elsewhere than in our Journal, briefs have been run on selected articles from other medical journals. The medical abstracts were moved from the back of the Journal to the front form immediately following the original articles.

In spite of the shortage of paper stock, manpower problems and other difficulties, your Journal has been mailed regularly each month. There is paper in stock for several months. While the future of all publications seems rather uncertain, there is no definite indication that the publication of our Journal will be disrupted during the coming year. Our printer has given excellent cooperation and deserves special commendation.

As we have mentioned many times, this is your Journal and we are trying to publish it in accordance with your wishes. Constructive criticisms are solicited.

Respectfully submitted,  
Shaler Richardson,  
Stewart Thompson.

CHARLES H. GOODRICH  
Certified Public Accountant  
JACKSONVILLE (1), FLORIDA  
April 6, 1944

Dr. Shaler Richardson, Treasurer  
Florida Medical Association, Inc.  
Jacksonville, Florida

Dear Sir:

Pursuant with the terms of my engagement, I have examined the statements of Receipts and Disbursements of the Florida Medical Association, Incorporated, furnished by the office of Dr. S. G. Thompson, Managing Director, for the period March 30, 1943 to and including March 27, 1944, together with the accompanying Exhibits "A" to "G," inclusive, and the consolidated Cash Statement.

These statements have been found in agreement with the books of account of the Association and correctly reflect the cash transactions for the period stated. Cancelled checks covering disbursements were checked to the records, found in order and in my opinion for proper purposes. All receipts covering cash collections were traced to the bank deposits and all bank balances have been reconciled with the books of account and independently verified by the depositories.

Treasury bond of a face value of \$10,000.00 was verified as being with the Atlantic National Bank, as Custodian, and War Bonds of a maturity value of \$20,325.00 were verified by inspection.

Income from advertising in the Association's Journal was verified substantially by comparison with a statement of contracts furnished by the Director's office.

Records of the various County Societies being inaccessible for the purpose of checking remittances for dues, attention is directed to Exhibit "D" herewith, which displays the detail regarding this matter.

Yours very truly,  
(Signed) Charles H. Goodrich.

**CONSOLIDATED CASH STATEMENT**  
March 30, 1943 through March 27, 1944

*Receipts*

Cash in Bank, March 30, 1943	\$26,828.60
Dues and Entrance Fees Collected (Exhibit "D")	\$10,380.00
Earnings from Advertising (Exhibit "E")	5,597.66
Profit from Reprints (nonmembers)	42.41
Subscription and Misc. Sale of Journal and Directory (Exhibit "F")	642.80
Interest on Savings and Investment	280.20
Cash Donations for Purchase of War Bonds	473.50
Miscellaneous Income	4.08
Earnings from Technical Exhibits (Exhibit "C")	1,620.00
	19,040.65

Total Cash to be Accounted for \$45,869.25

*Disbursements*

General Fund Expenses (Exhibit "A")	\$ 9,086.66
Journal and Directory Expenses (Exhibit "B")	7,781.19
Technical Exhibit Expenses (Exhibit "C")	544.70
Committee Expenses (Exhibit "A")	1,578.55
Library	39.95
Federal Tax	36.26
Investment—Purchase of War Bonds	11,840.00
	30,907.31
Balance in Bank, March 27, 1944	\$14,961.94

**EXHIBIT "A"**

**CASH STATEMENT—GENERAL FUND**  
March 30, 1943 through March 27, 1944

*Receipts*

Cash as per last audit	\$26,828.60
Back Dues Collected (Exhibit "D")	\$1,390.00
Current Dues Collected (Exhibit "D")	8,440.00
Entrance Fees Collected (Exhibit "D")	550.00
	10,380.00
Interest on Savings and Investment	280.20
Miscellaneous Income	4.08
Cash Donations for Purchase of War Bonds	473.50
From Exhibit Fund (Income Above Cost)	1,075.30
	\$39,041.68

*Disbursements*

Postage and Supplies	\$ 234.53
Telephone and Telegraph	109.75
Salaries*	7,270.00
Traveling Expense	230.29
Delegates' (2) Transp. to Chicago	176.91
Legal Counsel	100.00
Office Rent	720.00
Towel Service	15.00
Auditing Books	17.50
Electrotypes and Mats	1.40
Messenger Service	22.35
Bank Exchange	2.38
Custody of Bonds	10.00
Clipping Service	60.00
Treasurer's Bond	18.75
Subscrip. Times-Union	13.20
Employers' Liability Insurance	14.00
Repair and Service to Furn., Fix. & Equip.	52.25
Incidental	1.35
Rental, Safety Dep. Box	17.00
	9,086.66
Committees:	
Council	4.79
Legislation & Public Policy	1,552.05
Board of Governors	1.55
Scientific Work	10.91
Miscellaneous Com- mittee Expense	9.25
	1,578.55
Purchase of War Bonds (1—\$1,000 at \$740, (1—\$5,000 at \$3,700, (1—\$10,000 at \$7,400)	11,840.00
Library	39.95
Federal Tax	36.26
To Jrn. & Directory Fund (Cost above Income)	1,498.32
Cash Balance	24,079.74
	\$14,961.94

\*Total Salaries, Income tax and Victory tax deducted from this amount and paid to Collector of Internal Revenue.

## EXHIBIT "B"

## CASH STATEMENT—JOURNAL AND DIRECTORY

## FUND

March 30, 1943 through March 27, 1944

## Receipts

Cash as per last audit .....	\$ .00
Earnings from Advertising (Exhibit "E") .....	\$5,597.66
Subscriptions & Misc. Sale (Exhibit "F") .....	642.80
Profit from Reprints (nonmembers) .....	42.41
From General Fund .....	1,498.32
	7,781.19

To be Accounted for .....

\$7,781.19

## Disbursements

Postage and Supplies .....	286.05
Printing and Stock .....	4,391.30
Telephone and Telegraph .....	123.24
Salaries* .....	2,849.00
Dray .....	40.17
Auditing Books .....	17.50
Treasurer's Bond .....	18.75
Cuts and repair of cuts .....	34.18
Addressograph Service and Repair .....	10.45
Copyright, 1944 Directory .....	2.00
Reprints: "Preparation of Scientific Papers" .....	8.55
	7,781.19

Cash Balance .....

\$ 0.00

\*Total Salaries, Income tax and Victory tax deducted from this amount and paid to Collector of Internal Revenue.

## EXHIBIT "C"

## CASH STATEMENT—EXHIBIT FUND

March 30, 1943 through March 27, 1944

## Receipts

Cash as per last audit .....	\$ 0.00
Earnings from Technical Exhibits .....	1,620.00

To be Accounted for .....

\$1,620.00

## Disbursements

Convention Expense:	
Postage & Supplies .....	\$ 5.00
Telephone & Telegraph .....	35.27
Floor Plan & Electrotype .....	11.45
Identification Signs, Labor, etc. in Exhibit Hall .....	83.50
Printing & Photostats .....	13.50
Programs (1943 & 1944) .....	70.50
Badges .....	27.10
Misc. Expense and Employees' Travel .....	42.70
News Service, Cuts & Mats .....	8.90
Proceedings Reporter .....	31.58
Refreshments, Members and Guests .....	178.60
Incidental .....	36.60
	544.70
To General Fund (Income above Cost) .....	1,075.30
	1,620.00

Cash Balance .....

\$ 0.00

## EXHIBIT "E"

## EARNINGS FROM ADVERTISING

March 30, 1943 through March 27, 1944

April, 1943 .....	\$ 478.24
May .....	499.37
June .....	381.39
July .....	76.40
August .....	382.98
September .....	347.95
October .....	472.12
November .....	378.00
December .....	386.85
January, 1944 .....	462.04
February .....	432.55
March .....	687.91

Refund, A.M.A. ....

\$4,985.80  
611.86

Total .....

\$5,597.66

## EXHIBIT "F"

## EARNINGS FROM SUBSCRIPTIONS AND MISCELLANEOUS SALE OF JOURNAL AND DIRECTORY

March 30, 1943 through March 27, 1944

April, 1943 .....	\$ 6.60
May .....	7.80
June .....	13.60
July .....	6.00
August .....	3.20
September .....	18.00
October .....	1.00
November .....	12.30
December .....	15.00
January, 1944 .....	32.00
February .....	11.00
March .....	31.30

State Board of Health, 1943 Directory .....

\$157.80  
485.00

Total .....

\$642.80

## ASSETS AND LIABILITIES

March 27, 1944

## Assets

Cash in Fla. Natl. Bank Checking Acct. ....	\$12,443.08
Cash in Barnett Natl. Checking Acct. ....	902.67
(Postgraduate Course Committee Acct.) ....	
General Fund—Accounts Receivable .....	900.00
Journal & Directory—Accounts Receivable .....	1,009.74
Furniture, Fixtures & Equipment .....	880.88
(less depreciation) .....	
Library .....	831.91
Stationery Inventory .....	995.63
Savings: Atlantic National Bank .....	744.86
Barnett National Bank .....	1,774.00
Investments: Treasury Bond .....	10,178.13
War Savings Bonds .....	15,040.50

\$45,701.40

## Liabilities

Postgraduate Course Committee .....	902.67
Capital Account .....	44,798.73

\$45,701.40

## EXHIBIT "D"

DUES AND ENTRANCE FEES COLLECTED MARCH 30, 1943, THROUGH MARCH 27, 1944

Name of Society	Total Members	No. Paid Members	No. In Arrears	1944 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	27	24	3	150.00	40.00	10.00
Bay	14	14	0	90.00	10.00	20.00
Brevard	11	9	2	60.00		
Broward	41	41	0	280.00	10.00	20.00
Columbia	12	12	0	100.00		
Dade	350	325	25	1,850.00	490.00	170.00
DeSoto-Hardee-Highlands-Charlotte-Glades	20	20	0	150.00	-10.00	
Duval	194	190	4	1,190.00	160.00	60.00
Escambia	48	43	5	260.00	20.00	
Franklin-Gulf	6	6	0	50.00		20.00
Hillsborough	105	95	10	630.00	160.00	60.00
Jackson	12	12	0	100.00		
Lake	18	17	1	90.00	20.00	
Lee	17	17	0	100.00	20.00	
Leon-Gadsden-Liberty-Wakulla-Jefferson	39	33	6	220.00	30.00	
Madison-Suwannee	9	9	0	40.00		10.00
Manatee	12	12	0	70.00		
Marion	26	25	1	140.00	10.00	
Monroe	6	3	3		10.00	10.00
Nassau	8	7	1	50.00	10.00	10.00
Orange	95	91	4	540.00	110.00	50.00
Palm Beach	64	62	2	430.00	20.00	
Pasco-Hernando-Citrus	11	11	0	90.00	10.00	
Pinellas	108	108	0	720.00	50.00	70.00
Polk	62	52	10	360.00	30.00	10.00
Putnam	9	9	0	60.00		
St. Johns	12	12	0	70.00		
St. Lucie-Okeechobee-Indian River-Martin	17	17	0	160.00	70.00	
Sarasota	18	18	0	80.00	20.00	10.00
Seminole	13	13	0	70.00	20.00	20.00
Taylor	4	4	0	30.00		
Volusia	43	30	13	120.00	80.00	
Walton-Okaloosa	6	6	0	50.00		
Washington-Holmes	6	6	0	40.00		
<b>Totals</b>	<b>1,443</b>	<b>1,353</b>	<b>90</b>	<b>8,440.00</b>	<b>1,390.00</b>	<b>550.00</b>
				<b>1,390.00</b>	<b>Back dues Collected</b>	
<i>Dues Not Payable</i>						
Co. Soc. Secys.	33			9,830.00	Total dues Collected	
Life & Honorary	58			550.00	Entrance fees Collected	
Military Service	418	509				
<b>Paying Dues</b>	<b>844</b>			<b>\$10,380.00</b>	<b>Dues and Entrance Fees</b>	

EMERGENCY FUND (Memorandum No. 7)  
(Taken from Treasurer's Financial Statement)  
March 30, 1943 through March 27, 1944

Debit	
Balance on Hand, March 30, 1943 (Memorandum No. 6)	\$ 97.79
Back Dues Collected (Exhibit "D") \$1,390.00 (139 members at \$2.50)	\$ 347.50
Current Dues Collected (Exhibit "D") \$8,440.00 (844 members at \$2.50)	2,110.00
To be Accounted for	2,457.50
Less Amount Reserved for Working Budget and Expended	1,500.00
Balance	\$1,055.29

Credit	
Committee Expenses:	
Council	4.79
Legislation & Public Policy	1,552.05
Board of Governors	1.55
Scientific Work	10.91
Miscellaneous Committee Expenses	9.25
Balance—(Overdraft)	1,578.55

MEDICAL POSTGRADUATE COURSE—II  
March 30, 1943 through March 27, 1944

Receipts	
Cash as per last audit	\$ 1,110.06
Registration Fees, 1943 Postgraduate Course (123 at \$5.00)	615.00
To be Accounted for	\$1,725.06
Expenditures	
Attorney's fee	\$ 33.50
Faculty Honoraria and Expenses:	
Dr. R. W. Wilkins	\$229.69
Dr. Alton Ochsner	127.29
Dr. Howard Payne	100.00
Dr. Austin Deibert	75.00
Geo. Washington Hotel	78.81
	610.79
Attendant at Registration Desk	25.00
Stenographer's Salary	100.00
Telephone, Telegrams & Postage	15.00
U. of Fla.—Salaries 38 members of Faculty of Dept. of Medicine at \$1.00	38.00
Bank Exchange	.10
Balance in Bank	\$ 902.67

The guest speaker, Dr. Edgar G. Ballenger of Atlanta, president-elect, Southern Medical Association, was introduced by Dr. McIver.

Address, "The Relationship of Obstructive Lesions to Urologic Affections," by Dr. Ballenger.

Dr. Peek: Dr. Ballenger, on behalf of the Florida Medical Association I wish to thank you for this wonderful paper.

There were no delegates present from other state societies.

Announcements: All members were requested to register and visit the various exhibit booths.

Dr. McConnell announced that refreshments would be served in the rear of the assembly room at 5:30 p. m. He also invited members and guests to avail themselves of the facilities of the Army and Navy Club during the convention.

There being no further business, a motion to adjourn prevailed.

## SECOND GENERAL SESSION

The meeting of the Florida Medical Association reconvened at 12:00 noon, Friday, April 14, 1944, in the Assembly Room of the Princess Martha Hotel; President Peek in the chair.

The meeting was called to order.

Dr. McIver: We have met in St. Petersburg before and always had a wonderful time. We have met here this time under trying circumstances with the country at war and we still had a wonderful time. I move that the President of this Association call for a rising vote of thanks to the Pinellas County Medical Society for the wonderful entertainment they have given us.

At the request of the president the members gave a rising vote of thanks to the Pinellas County Medical Society.

The first item of business was the election of officers.

Nominations for president-elect were called for.

Dr. Bryans: I wish to nominate a man who has unselfishly served this Association in a most efficient manner continuously for a period of nineteen years.

During the next year or two organized medicine will face many serious problems and we will be fortunate to have a man with the wisdom he has gained by so many years' experience. In addition to the years of service with the State Association he is also a past president of the State Board of Health.

I think it is a fitting climax to his many years of service that we elect to the highest office in this Association, Dr. Shaler Richardson.

Nomination seconded by Dr. John McEwan of Orlando.

Motion by Dr. Goodale that the nominations be closed and that Dr. Richardson be declared unanimously elected. Seconded. Motion prevailed.

Dr. Richardson: Mr. President and Members of the Association: I am sincerely grateful to you for this honor, for I feel that it is indeed an honor to be president-elect of this organization. The nineteen years I have served as secretary-treasurer and editor of the Journal were truly enjoyed by me from beginning to end. I enjoyed the contacts with various members of the Association and their cooperation has been so whole-hearted that it really has been a pleasant nineteen years.

I want to assure you that when I become your president I will endeavor in every way to promote the interests of the Florida Medical Association.

Nominations for first vice president were called for.

Dr. Waas: I would like to nominate a man who has, I think, demonstrated to us that under wartime conditions this community can put over a good meeting. I would like to nominate Dr. W. C. McConnell as first vice president.

Motion by Dr. Day that the nominations be closed and Dr. McConnell declared first vice president. Seconded. Motion prevailed.

Nominations for second vice president were called for. Dr. John McEwan nominated Dr. H. A. Day of Orlando. Motion made and seconded that the nominations be closed and that the secretary cast a unanimous vote for Dr. Day. Motion prevailed.

Nominations for third vice president were called for. Dr. Van Schaick nominated Dr. R. D. Ferguson of Ocala. Motion was made and seconded that the nominations be closed and that the secretary cast a unanimous vote for Dr. Ferguson. Motion prevailed.

Nominations for secretary and treasurer were called for.

Dr. Rowlett: Mr. President and fellow members: I want to nominate, Mr. President, a man for this exalted position who has devoted the best years of his life to the work of organized medicine. He has served us faithfully, and also the State Board of Health. Besides his various other essential qualifications, he resides in the City of Jacksonville where the headquarters of our Association are located. It gives me a great deal of pleasure to nominate for this important position, Dr. Robert McIver of Jacksonville.

It was moved and seconded that the nominations be closed and Dr. McIver declared unanimously elected. Motion prevailed.

Nominations for editor of the Journal were called for.

Dr. Jelks: I should like to nominate for editor of the Journal one of the members of this Association who has been active in the various offices from the bottom to the top, a man who has had many years of experience in publication work, having published the Bulletin of the Dade County Medical Society. I would like to nominate as editor of the Journal, Dr. Homer Pearson of Miami.

Motion made and seconded that the nominations be closed and Dr. Pearson declared unanimously elected. Motion prevailed.

The chair requested Dr. Jones and Dr. Waas to escort Dr. Boling to the rostrum.

Dr. Peek: I want to thank the members of the Association for the wonderful cooperation given me, which in my opinion has helped us to do the wonderful amount of work that has been done. It would have been a complete failure without the one hundred per cent cooperation I have had during the past year.

Dr. Boling, I hope that you will have this same complete cooperation and that you will end your term of office, as I end mine, grateful for a year of the greatest pleasure experienced since I began the practice of medicine.

Dr. Boling: I am very greatly honored and very, very proud.

In the absence of Dr. H. Marshall Taylor the chair called upon Dr. F. J. Waas to present the past president's button to Dr. Peek.

Dr. Waas: Dr. Peek, it is certainly a signal honor, my pinch-hitting for Dr. Marshall Taylor today. I simply want to say that this is indeed a very great pleasure, privilege and honor. We all feel that you have performed an outstanding duty this past year under the existing circumstances. It is now my pleasure to present to you the past president's button and to welcome you to the role of a Past President.

There being no further business, on motion duly made and seconded, the president sounded the gavel and declared the Seventy-first Annual Meeting of the Florida Medical Association adjourned, sine die.

## HOUSE OF DELEGATES

### FIRST HOUSE OF DELEGATES

The House of Delegates convened at 3:30 p.m., Thursday, April 13, 1944, in the Assembly Room of the Princess Martha Hotel, St. Petersburg, with Dr. Eugene G. Peek, president, in the chair. Delegates answering Roll Call are shown in regular type. Delegates not answering Roll Call are shown (*absent*).

#### DELEGATES

ALACHUA—Thomas A. Snow.  
 BAY—J. M. Nixon.  
 BREvard—I. F. Bean.  
 BROWARD—L. L. Stepp, C. A. Peterson.  
 COLUMBIA—Robert B. Harkness.  
 DADE—Walter C. Jones, W. L. Fitzgerald, Homer L. Pearson, Wiley M. Sams, James L. Anderson, H. A. Barge, Colquitt Pearson, Harrison Walker, S. W. Page, F. A. Vogt, J. R. Graves, G. E. Chandler, P. J. Manson. (*Absent*—M. Jay Flipse, Walter Hotchkiss, P. B. Welch.)  
 DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES — M. C. Kayton.  
 DUVAL—B. H. Goodale, T. Z. Cason, S. E. Driskell, L. V. Dyrenforth, Henry Hanson, Edward Jelks, Louie Limbaugh, J. G. Lyerly, R. R. Killinger, K. A. Morris.  
 ESCAMBIA—Herbert L. Bryans, J. N. McLane.  
 FRANKLIN-GULF—(*Absent*).  
 HILLSBOROUGH—H. Mason Smith, E. F. Shaver, Charles Gray, W. M. Rowlett, A. M. Bidwell.  
 JACKSON—C. D. Whitaker.  
 LAKE—R. H. Williams.  
 LEE—H. Q. Jones.  
 LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON — B. A. Wilkinson, J. H. Pound.  
 MADISON-SUWANNEE—(*Absent*, T. K. Slaughter, Jr.).  
 MANATEE—(*Absent*, W. D. Sugg).  
 MARION—R. D. Ferguson.

MONROE—(*Absent*).

NASSAU—George A. Dame.

ORANGE—Spencer A. Folsom, T. E. McBride, H. A. Day, J. S. McEwan.

PALM BEACH—E. W. Stephens, Gaylord Lewis, J. H. Pittman.

PASCO-HERNANDO-CITRUS—S. C. Harvard.

PINELLAS—J. A. Hardenbergh, W. C. McConnell, R. H. Knowlton, A. M. Feaster, A. J. Wood.

POLK—J. R. Boulware, Herman Watson, W. F. Peacock.

PUTNAM—(*Absent*, J. W. Brantley).

ST. JOHNS—Herbert E. White.

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN—L. L. Whiddon.

SARASOTA—(*Absent*, Joseph Halton).

SEMINOLE—Leland H. Dame.

TAYLOR—W. J. Baker.

VOLUSIA—Hugh West. (*Absent*, George M. Green).

WALTON-OKALOOSA—(*Absent*: R. B. Spires).

WASHINGTON-HOLMES—(*Absent*, B. W. Dalton).

ASSOCIATION OFFICERS—Eugene G. Peek, John R. Boling, Louie Limbaugh, Lloyd J. Netto, Carl E. Dunaway, Shaler Richardson.

The chair declared a quorum present.

It was moved and seconded that the minutes of the last meeting, as published in the June, 1943, issue of the Florida Medical Journal, be adopted. There being no corrections or amendments, on motion by Dr. Driskell, the minutes as published were adopted by unanimous vote.

Our delegates to the A. M. A. House of Delegates were then recognized.

Delegate Dr. Jelks: Our report has already been published in the Journal. Since that report was made there has been action taken by the Florida Hospital Association and presented at the House of Delegates of the A. M. A. which I would like to bring to your attention.

The Florida Hospital Association is in the process now of introducing in Florida the Blue Cross plan for hospital service. This is said to be a purely nonprofit hospital service. This was brought out fully at the meeting of the A. M. A. House of Delegates and they took a clear, distinct and firm stand on this question of hospital service. I will read one paragraph from a resolution passed which bears out the action of the A.M.A.

The House of Delegates emphatically reiterates that it disapproves the injecting of a third party into the present relationship between patient and physician and that hospitals should not be permitted to practice medicine.

I would like to give you this information. Certain members of the Hospital Association of Florida have talked with me as a House of Delegates' representative and said they would like very much for this House of Delegates to take some certain stand. They want to initiate this Blue Cross hospital plan in Florida and they want a representative of this body to serve with the Board of Directors of the Florida Hospital Association.

Delegate Dr. Mallory had nothing to add.

President Peek called for the nomination of one delegate to the House of Delegates of the A. M. A. for a two-year term beginning January, 1945, reading Chapter 1, Sec. 1 of the A. M. A. By-Laws, as follows:

A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.

Dr. Bryans nominated Dr. Jelks. Dr. Barge moved that the nominations be closed and that Dr. Jelks be elected. Motion seconded and carried.

The chair called for nominations of an alternate. Dr. Mallory was nominated by Dr. Ferguson who moved that nominations be closed and that Dr. Mallory be elected. Motion seconded by Dr. Van Schaick and carried.

The chair announced the personnel of three reference committees as follows:

1. HEALTH AND EDUCATION:

Herbert E. White, *Chairman*  
Louie Limbaugh  
Homer L. Pearson  
H. Mason Smith  
R. H. Knowlton

2. PUBLIC POLICY:

Walter C. Jones, *Chairman*  
Edward Jelks  
Herman Watson  
Spencer A. Folsom  
Lloyd J. Netto

3. FINANCE AND ADMINISTRATION:

Shaler Richardson, *Chairman*  
Wiley M. Sams  
John R. Boling  
W. M. Rowlett  
W. C. McConnell

The chair announced that the reference committees would meet immediately after the adjournment of the First Scientific Assembly.

A resolution was read by Dr. H. A. Day concerning the fee schedule set by the Industrial Commission of the State of Florida. On motion the resolution was received and referred by the chair to Reference Committee No. 1, Health and Education.

A resolution was read by Dr. Thomas A. Snow relative to the practice of obstetrics in the State of Florida. On motion the resolution was received and referred by the chair to Reference Committee No. 2, Public Policy.

A resolution was read by Dr. Walter C. Jones relative to the Blue Cross hospital plan of service. On motion the resolution was received and referred by the chair to Reference Committees No. 1, Health and Education and No. 2, Public Policy.

Dr. Walter C. Jones moved that the date and place of the 1945 Annual Meeting of the Florida Medical Association be left to the Board of Governors. Seconded by Dr. Netto. Motion prevailed.

Dr. Peek: I would like to recommend that the meeting place be selected in some central location which would be easily accessible both to the members and to the invited guests for the duration of the present emergency.

The report of the Board of Governors was read by Dr. Robert D. Ferguson, chairman. On motion the report was received and referred by the chair to Reference Committee No. 3, Finance and Administration.

The report of the Committee on Scientific Work was read by Dr. Herbert E. White, chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Legislation and Public Policy was read by Dr. W. M. Rowlett, chairman. On motion the report was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Medical Education and Hospitals, sent in by Dr. Holland, chairman, was read by the secretary. On motion, the report was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Public Relations was read by Dr. Leigh F. Robinson, chairman. On motion the report was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Necrology was read by Dr. Gerry Holden, chairman. At the request of the president the members stood for a moment in silent respect to the memory of departed colleagues.

The report of the Committee on Medical Postgraduate Course was read by Dr. T. Z. Cason, chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Cancer Control was read by Dr. John N. Moore, chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on Medical Economics was read by Dr. Ferdinand A. Vogt, chairman. On motion the report was received and referred by the chair to Reference Committee No. 2, Public Policy.

In the absence of the chairman, Dr. E. T. Sellers, no report was presented by the Committee on Venereal Disease Control.

The report of the Committee on Interrelationship was read by Dr. William M. Davis, chairman. On motion the report was received and referred by the chair to Reference Committee No. 2, Public Policy.

The report of the Committee on Tuberculosis and Public Health was read by Dr. William C. Blake, chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

A verbal report was made by Dr. H. Mason Smith, chairman of the Committee on State Controlled Medical Institutions.

The report of the Committee on Maternal Welfare was read by Dr. William C. Thomas, chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

In the absence of the chairman, Dr. George L. Cook, no report was made by the Committee on Child Health.

In the absence of the chairman, Dr. George C. Tillman, no report was made by the Advisory Committee to the Woman's Auxiliary.

In the absence of the chairman, Dr. J. C. Davis, no report was made by the Committee as Representatives to the Industrial Council.

The report of the Council was read by Dr. Lloyd J. Netto, chairman. On motion the report was received and referred by the chair to Reference Committee No. 3, Finance and Administration.

The report of the Committee on Conservation of Vision was read by Dr. Shaler Richardson, chairman. On motion the report was received and referred by the chair to Reference Committee No. 1, Health and Education.

The report of the Committee on War Participation was read by Dr. Edward Jelks, chairman. On motion the report was received and referred by the chair to Reference Committee No. 3, Finance and Administration.

In the absence of the chairman, Dr. H. Marshall Taylor, no report was made by the Board of Past Presidents.

No report was made by the Committee on Publication.

The chair called for new business and Dr. T. Z. Cason presented verbally the request for cooperation by the Vocational Rehabilitation Service of the State Department of Education. He was requested by the chair to put this in writing and present it to the Board of Governors at their next meeting.

There being no further business to come before the meeting, on motion seconded and carried the House recessed to reconvene Friday, April 14, at 9:30 a. m.

## SECOND HOUSE OF DELEGATES

The House of Delegates reconvened at 9:50 a. m., Friday, April 14, in the Assembly Room of the Princess Martha Hotel, St. Petersburg; President Peek in the chair. Delegates answering Roll Call are shown in regular type. Delegates not answering Roll Call are shown (*absent*).

### DELEGATES

ALACHUA—Thomas A. Snow.

BAY—(*Absent*, J. M. Nixon.)

BREVARD—I. F. Bean.

BROWARD—C. A. Peterson. (*Absent*, L. L. Stepp.)

COLUMBIA—Robert B. Harkness.

DADE—Walter C. Jones, W. L. Fitzgerald, Homer L. Pearson, Wiley M. Sams, H. A. Barge, S. W. Page, Colquitt Pearson, Harrison Walker, J. R. Graves, G. E. Chandler, P. J. Manson. (*Absent*, James L. Anderson, M. Jay Flipse, Walter Hotchkiss, F. A. Vogt, P. B. Welch.)

DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADE:—(*Absent*, M. C. Kayton.)

DUVAL—B. H. Goodale, T. Z. Cason, S. E. Driskell, L. Y. Dyrenforth, Henry Hanson, Edward Jelks, Louie Limbaugh, J. G. Lyerly, R. R. Killinger, K. A. Morris.

ESCAMBIA—Herbert L. Bryans. (*Absent*, J. N. McLane.)

FRANKLIN-GULF—(*Absent*.)

HILLSBOROUGH—E. F. Shaver, Charles Gray, W. M. Rowlett. (*Absent*, H. Mason Smith, A. M. Bidwell.)

JACKSON—C. D. Whitaker.

LAKE—R. H. Williams.

LEE—H. Q. Jones.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—B. A. Wilkinson, J. H. Pound.

MADISON-SUWANNEE—(*Absent*, T. K. Slaughter, Jr.)

MANATEE—(*Absent*, W. D. Sugg.)

MARION—R. D. Ferguson.

MONROE—(*Absent*.)

NASSAU—George A. Dame.

ORANGE—Spencer A. Folsom, T. E. McBride, H. A. Day, J. S. McEwan.

PALM BEACH—J. H. Pittman. (*Absent*, E. W. Stephens, Gaylord Lewis.)

PASCO-HERNANDO-CITRUS—S. C. Harvard.

PINELLAS—J. A. Hardenbergh, W. C. McConnell, A. M. Feaster, A. J. Wood. (*Absent*, R. H. Knowlton.)

POLK—J. R. Boulware, Herman Watson, W. F. Peacock.

PUTNAM—(*Absent*, J. W. Brantley.)

ST. JOHNS—Herbert E. White.

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN—L. L. Whiddon.

SARASOTA—(*Absent*, Joseph Halton.)

SEMINOLE—Leland H. Dame.

TAYLOR—(*Absent*, W. J. Baker.)

VOLUSIA—George M. Green. (*Absent*, Hugh West.)

WALTON-OKALOOSA—(*Absent*, R. B. Spires.)

WASHINGTON-HOLMES—(*Absent*, B. W. Dalton.)

ASSOCIATION OFFICERS—Eugene G. Peek, John R. Boling, Lloyd J. Netto, Carl E. Dunaway, Shaler Richardson. (*Absent*, Louie Limbaugh.)

The chair declared a quorum present.

The meeting was called to order.

### REPORT OF REFERENCE COMMITTEE NO. 1

Dr. Herbert E. White, chairman of Reference Committee No. 1, Health and Education, was recognized and asked to present the recommendations of that committee.

"The Committee recommends the adoption and publication of the report of the Committee on Conservation of Vision."

Motion made and seconded that the report be adopted and published. Motion prevailed.

REPORT OF COMMITTEE ON CONSERVATION OF VISION

Your Committee on Conservation of Vision has cooperated with the Florida Council for the Blind in taking care of many indigent ophthalmic patients during the past year.

It is recommended that our members visit the exhibit booth of the Florida Council for the Blind.

Respectfully submitted,  
Shaler Richardson, *Chairman.*

"The Committee recommends the adoption and publication of the report of the Committee on Scientific Work."

Motion made and seconded that the report be adopted and published. Motion prevailed.

REPORT OF COMMITTEE ON SCIENTIFIC WORK

The report of our committee will be very brief. It was necessary this year for our committee to transact most of its business through correspondence.

One of the duties of the Scientific Work Committee was to secure eight doctors to present papers at the scientific sessions. Your program today indicates the results of our efforts. We feel that the scientific program this year will be exceptionally good. Most of the speakers appear by special invitation. We are gratified that so many of the distinguished speakers accepted the invitation to appear on the scientific program.

I wish to express appreciation for the cooperation of the officers of the Association, friends and members of the Scientific Work Committee, who cooperated in the preparation of this part of the program.

Respectfully submitted,  
Herbert E. White, *Chairman.*

"The Committee approves the program of the Vocational Rehabilitation Service of the State Department of Education, and recommends that the details of this service be worked out with the Committee on Medical Economics of the Florida Medical Association."

Motion made and seconded that the recommendations of the committee be carried out. Motion prevailed. (*Resolution not turned in.*)

"The Committee recommends the adoption and publication of the report of the Committee on Medical Postgraduate Course."

Motion made and seconded that the report be adopted and published. Motion prevailed.

REPORT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE

The interest in the Graduate Short Course continues to increase. Last year's session was held at the George Washington Hotel in Jacksonville, June 21-26, inclusive. The attendance was 189. This was not quite as large as in 1942, but under the circumstances was exceedingly good. The total number from the Florida Medical Association was 97. Forty-seven members of the armed services attended and there were 17 visitors. There were 28 Negro physicians who attended under the auspices of the Florida Agricultural and Mechanical College.

There were 123 paid registrants at the 1943 session with the total receipts of \$615.00. At the last audit there was \$1,110.06 on hand, making a total to be accounted for of \$1,725.06. The total expenses for 1943 were \$822.29, leaving a balance in the treasury of \$902.67, thus running at a deficit of \$207.39. During the past year the corporation which controlled the funds of the Postgraduate Committee was dissolved. The funds have all been transferred to the Florida Medical Association and paid out only by the joint signature of the treasurer of the Association and the chairman of the Postgraduate Course Committee. We feel that this is a definite advantage.

Due to the advantages of transportation and hotel facilities, it was felt advisable to hold the 1944 Graduate Short Course in Jacksonville. The lectures will be given at the George Washington Hotel, June 19-24, inclusive. The course will be pretty much the same as last year except that twelve additional lectures have been added, four on Postwar Medicine, four on Postwar Surgery, and four on Postwar Public Health. The faculty will be as strong as it has been for the past several years. The completed program will be announced later. There will be no dinner meetings but there will be two sessions each evening. The evening meetings will be limited to forty-five minutes instead of the usual hour.

The Faculty of the Medical Department of the Graduate School of the University of Florida has been appointed. This procedure was followed in selecting the faculty: First, the selection was made by the Director and Chairman of the Postgraduate Committee together with the other members of the committee; second, these names were presented to the president of the university who made the appointments after they were confirmed by the Board of Control. Appointments are for one year only. For this reason no physicians in the armed forces were placed on the faculty. Other physicians will be selected as they are released from the services at the end of the war. It was planned that three types of graduate education would be offered by the Department: (1) Continuous courses to be taught by the faculty selected; (2) Graduate education offered to those in special fields, the lectures to be given by nationally recognized specialists who will be brought down for brief graduate instruction; these may be given at any place desired by the group; (3) It is planned when the medical district meetings are resumed that at least one day's graduate education will be given at each of these meetings, these lectures to be given by the faculty of the Medical Department. Each hour's attendance by those taking any of the graduate courses offered will be registered at the University of Florida and due credit given.

Respectfully submitted,  
T. Z. Cason, *Chairman.*

"The Committee recommends the adoption and publication of the report of the Committee on Cancer Control."

Motion made and seconded that this report be adopted and published. Motion prevailed.

## REPORT OF COMMITTEE ON CANCER CONTROL

Due to transportation difficulties, this committee has been handicapped to the extent that communication has largely been limited to personal contact, mail and telephone.

No constructive work has been accomplished except educational, working with the Woman's Field Army. This organization, working under the American Society for the Control of Cancer, has been very active under the able direction of Mrs. Malcolm Smith of Tampa.

The highlights of accomplishment for 1943-1944 are as follows: (1) Counties organized: Bay, Calhoun, Dade, Duval, Gulf, Jackson, Jefferson, Leon, Liberty, Nassau, Volusia, Walton, Hillsborough, Holmes, Sarasota, and Okaloosa. (2) Counties without a commander but having several town units: Lake and Polk. (3) Counties not organized but having educational work: Escambia, Citrus, Alachua, Union, Levy, Gilchrist, Baker, Brevard, Dixie, Sumter, Putnam, Marion and Clay.

Realizing that our greatest weapon in fighting cancer is the education of the public, emphasizing early diagnosis and early treatment, there is a wide-spread move to present the facts concerning cancer through appropriate courses in the public schools. Hillsborough County has purchased textbooks for all tenth grade students in biological and physical education classes. Eventually it is expected that all schools of the state will include such studies.

Arrangements have been made with the State Defense Council whereby block leaders and other committees will distribute leaflets to every home in the community. Miami and Jacksonville have asked for 150,000 of these leaflets.

In many instances it has been impossible to get co-operation from the county medical society in those counties in which a unit of the Woman's Field Army is organized. Except in a few instances, the only concerted drive against cancer is being performed by the Woman's Field Army, and it behoves the State Medical Association to give more active support. It is, therefore, suggested that the committeeman of each state division be empowered to advise and direct the activities of the respective county societies in their relationship with the Woman's Field Army.

While emphasizing the importance of educating the laity and the profession in the signs and symptoms of cancer, we are aware that the appalling death rate from cancer can be materially reduced only by early efficient therapeutic measures administered by those trained in this field. This service should be accessible to the entire population irrespective of financial status. In our state there are only a few cancer clinics that are available to the indigent patients, and only to the citizens of the county in which located. This leaves a vast area in which no substantial aid in diagnosis and treatment can be secured by those not in a financial position to pay for such services. This committee believes that the cancer control situation in the State of Florida can best be promoted by state legislation which sets aside a definite sum each year for the establishment of cancer clinics for the indigent, with the following organizations cooperating: (1) State Department of Health—Cancer Control Service, (2) State Cancer Commission—appointed by the State Medical Association, and (3) the Woman's Field Army.

If such a law be carefully drawn, insisting on minimum requirements in personnel and equipment for all clinics, as outlined by the American College of Surgeons, safeguarding infringement by applicants for treatment, it will materially redound to the mutual benefit of the medical profession and the population affected.

When the opportune time comes to launch such a program (perhaps after cessation of hostilities), we believe it would be wise to study carefully the operation of the cancer control program now in operation in the state of Georgia.

Your chairman has made a thorough investigation of the Georgia law, has interviewed the physicians in

charge of the clinics, the indigent patients requiring treatment, and from such information concludes that the setup is working satisfactorily. To some members of the profession such a program smacks of socialized medicine, but, if the medical profession loses some of its complacency and initiates such necessary Public Health measures, it will perhaps have a salutary effect in delaying potentialistic socialized medicine of the federal flavor.

Respectfully submitted,

J. N. Moore, Chairman.

"The Committee recommends the adoption and publication of the report of the Committee on Tuberculosis and Public Health."

Motion made and seconded that this report be adopted and published. Motion prevailed.

## REPORT OF COMMITTEE ON TUBERCULOSIS AND PUBLIC HEALTH

Your committee through the year has continued its service in an advisory capacity to the State Tuberculosis Sanatorium, the Division of Tuberculosis, State Board of Health, and the Florida Tuberculosis and Health Association. It has approved pamphlets and films prior to their distribution to the lay public and has recommended the distribution of approved technical material to physicians, nurses and other professional groups.

A change of policy was recommended by the committee during the year in connection with the mass roentgen examinations performed by the Mobile X-ray Unit of the Division of Tuberculosis, State Board of Health. In view of the need to conserve x-ray films, and the small amount of clinical tuberculosis discovered in school children, the committee recommended that no roentgen study be made of any person under 16 years of age, unless requested by the family physician, or unless the individual had been in direct contact with a known case of tuberculosis. The committee pointed out the increasing amount of tuberculosis in the elderly and recommended that in mass surveys, attention be focused upon groups in which the most tuberculosis is known to exist. These recommendations were accepted and are being enforced by the director of the Division of Tuberculosis.

The committee continued its cooperation with the committees of the State Board of Nurse Examiners and the State League of Nursing Education in the roentgen examination of student nurses in line with recommendations of the committee. Under the recommendations, training schools must provide roentgen examination of the chest of all students at the time of admission to the training school and annually thereafter, except when the student is on tuberculosis service and, in such cases, at six month intervals.

The committee cooperated with the Florida Tuberculosis and Health Association and Division of Tuberculosis, State Board of Health, and the State Tuberculosis Board in an effort to have roentgen examinations given to Bahamans brought into this country as laborers before they are allowed to mix with the population, or assigned to the job. While it was impossible to get this program instituted immediately, the Tuberculosis Control Division of the U. S. Public Health Service sent a portable x-ray unit to Miami for this survey. Unfortunately, the unit broke down and the program was not carried through. As a result of these efforts, however, the U. S. Public Health Service sent to Miami in the spring of 1944, 35 mm. x-ray equipment with a technician for the examination of laborers being imported from the West Indies. Approximately 1½ per cent of those examined are found to have tuberculosis. Before recommending deportation, 14x17 films are made and studied. All laborers found to have tuberculosis have been deported.

Your committee approved the selection of Dr. Henry D. Chadwick, Boston, formerly tuberculosis controller and Commissioner of Health for Massachusetts, as a surveyor to ascertain the need for additional tuberculosis beds in Florida. A report of this survey will be made public by the State Tuberculosis Board and the Florida Tuberculosis and Health Association within a short time.

The committee is pleased to present to this body, Dr. Henry C. Sweany, eminent authority on tuberculosis, as guest speaker at this annual meeting.

Respectfully submitted,

William C. Blake, *Chairman.*

"The Committee recommends the adoption and publication of the report of the Committee on Maternal Welfare."

Motion made and seconded that the report be adopted and published. Motion prevailed.

#### REPORT OF COMMITTEE ON MATERNAL WELFARE

This committee has not met except by correspondence. The only action of the committee has been to consider the federal payment for maternal care of wives of the first four grades in the Army and Navy personnel. The plan was agreed to but not approved, as it was considered that the obstetrical fee of \$35 was inadequate. Later the fee was raised to \$50. This fee has met with a much more general approval of the physicians of the state.

In addition to consideration of the Maternal Aid Plan, the chairman of the committee has been consulted by Dr. Marsh, the Chief of the Maternal Welfare Bureau of the State Board of Health, with reference to midwifery, maternal morbidity, and mortality. Nothing definite has been arrived at except that midwives should receive instructions as to their duties, and should be controlled. We also advised with Dr. Marsh with reference to a shorter form for records of obstetrical cases.

Respectfully submitted,

W. C. Thomas, *Chairman.*

"The Committee does not approve the resolution by Dr. Day relative to a change in the fee schedule which was set up by the Industrial Commission of the State of Florida, but recommends that it be referred back to the floor of the House of Delegates for discussion and clarification."

Resolution submitted by Dr. Day re-read by Dr. White.

Motion made and seconded that the resolution be referred back to the floor of the House of Delegates. Motion prevailed.

Dr. Day: Last year in Jacksonville at the meeting of the House of Delegates the Reference Committee recommended to the House of Delegates and the House of Delegates adopted the recommendation that this fee schedule act only as a guide. The purpose of this resolution is, as stated last year, to have this fee schedule act only as a guide. We hope you concur in this and will so rule on it.

Dr. L. Dame: Didn't Dr. Day bring up the same question last year?

Dr. Harrison Walker: I spoke on this subject yesterday before the Industrial Surgeons' meeting and gave just a little resume of what took place last year during which time I was chairman of the Economics Committee. I have sat at committee meetings both of the State Medical Association and the Industrial Surgeons. There

was quite a lot of procedure at the various meetings and a committee was appointed by the Florida Medical Association to meet with the Industrial group and help set up the fee schedule. There was also legislation passed wherein a fee schedule was requested to be made by the Industrial Commission. I believe the term was 'fee schedules'. There was some controversy between the Industrial group and the medical profession as to whether it should be a minimum fee schedule or a maximum fee schedule. The Industrial group held that it should be a maximum fee schedule and the physicians held that it should be a minimum. After considerable discussion, a committee was appointed to go into the subject. The outcome was that a meeting was called sixty days later in Jacksonville at which time the subject was discussed and a fee schedule agreed upon.

Since that time several other meetings of that same committee have been held.

The point that Dr. Day brings out in this resolution is that this schedule of fees be set as a guide for the profession to be governed by so that the fees charged would be the same as for similar or like private cases in the various communities. Of course the insurance people insist that this is a fee schedule instead of a guide and it seems to be quite the tendency for them to consider it as a maximum fee schedule and try to hold down the fees charged instead of considering it as a minimum fee schedule.

There is a ruling by the Attorney General on this subject and I believe that Dr. Day is absolutely correct in that if it were taken to court the Attorney General's opinion would be sustained. I believe that I would confirm Dr. Day's resolution in that he wishes this organization to go on record as recommending that this be a guide instead of an actual fee schedule.

Motion by Dr. Day that this resolution be adopted. Motion seconded.

Resolution re-read by Dr. Peek.

Dr. George Dame: If it said 'minimum' I could be more reconciled to the resolution, but because of the way it is written I will have to oppose it. I think if we adopt it as written that it will cause a great deal of confusion.

Dr. Peek: I will just read you one article from the original resolution:

Therefore, be it resolved that the House of Delegates of the Florida Medical Association go on record as adopting this report and also that they recommend that the component societies adopt this report and schedules of fees.

It is up to each county society to determine whether they can actually enforce it in their county; at least that would be my interpretation of the original resolution.

Dr. Ferguson: I am in favor of adopting the resolution. I think each county would have to submit to the Industrial Commission a fee schedule from their particular county.

Motion by Dr. Walter C. Jones that the resolution be tabled. Motion prevailed.

#### REPORT OF REFERENCE COMMITTEE No. 2

Dr. Walter C. Jones, chairman of Reference Committee No. 2, Public Policy, was recognized and asked to present the recommendations of that committee.

"The Committee had referred to it the question of the practice of obstetrics in the State of Florida. It is not a direct resolution, just presents the question for consideration. The Alachua County Medical Society felt that action should be taken concerning this question and if

possible the condition remedied. A committee met with the officers of the State Board of Health and the members of this committee referred it to the House of Delegates for discussion. It seems that only allopaths and osteopaths may practice obstetrics under the present maternity act. That is the part that we bring back with no action recommended to the House of Delegates unless you see fit to have a motion relative to this question."

Motion made and seconded that the report be received but not published in the Journal. Motion prevailed.

"The resolution on group hospitalization was discussed rather extensively by the Committee, and the Reference Committee recommends the adoption of the resolution with directions to the Committee representing the Florida Medical Association to adhere to the resolutions as passed by the House of Delegates of the American Medical Association in 1943—these resolutions in question were amendments to the report of the Board of Trustees of the American Medical Association. The Reference Committee on Health and Education has jointly approved this recommendation."

It was moved and seconded that the resolution be adopted and published. There was no discussion and the motion prevailed.

#### RESOLUTION ON GROUP HOSPITALIZATION

By Dr. Walter C. Jones

WHEREAS, in view of great stress being placed by legislative activities on the medical profession for adequate medical care, and

WHEREAS, as members of the House of Delegates of the Florida Medical Association, we realize the defects of the present system and need for improvement, and

WHEREAS, the Florida Hospital Association has a group plan for hospitalization under the Blue Cross plan; therefore, be it

RESOLVED that the House of Delegates of the Florida Medical Association approve this plan in principle and cooperate with the Florida Hospital Association in its endeavor, and be it further

RESOLVED that the president and Board of Governors specifically name members of the Florida Medical Association to serve in cooperation with the Florida Hospital Association in its installation of the plan.

"The Committee received the report of the Committee on Interrelationship and it was approved. We urge that the Committee be encouraged to continue their activity along the lines suggested."

It was moved and seconded that the report be adopted and published. There was no discussion and the motion prevailed.

#### REPORT OF COMMITTEE ON INTERRELATIONSHIP

Your Committee on Interrelationship with allied professions, according to the By-Laws, provides a means of discussion and the taking of concerted action on matters of common interest.

This being an off-legislative year, the war effort being paramount in our thinking and those of us left at home being busy above measure in carrying on, are factors which have precluded any particular activity of your committee.

The Bureau of Professional Relations of the School of Pharmacy of the University of Florida has continued its most welcome and efficient service to the medical profession which I am sure is valuable and appreciated. Dr. P. A. Foote, its director, is to be most heartily commended for his work. Dr. John E. Maines, Jr., Gainesville, a member of this committee, continues to exercise the privilege of checking new formulas and literature before they are issued.

There have been no other activities of your committee, yet we feel that some sort of definite organization with representatives of medical, dental, pharmaceutical, hospital and nurse associations, in line with what has already been accomplished in some states, would be advisable.

Wm. M. Davis, *Chairman.*

Appended is Special Report of the Bureau of Professional Relations to our Committee, which is made a part of this report.

#### SPECIAL REPORT

*Organization.* Early in 1940 the Florida State Board of Pharmacy proposed a program of Professional Relations between the physicians and pharmacists of the state. The plan was submitted to the House of Delegates of the Florida Medical Association in 1940 by Dr. E. C. Swift, who was then chairman of the Interrelationship Committee. The House of Delegates approved the use of the name of the Florida Medical Association on literature to be issued in this Professional Relations work. With funds supplied by the Florida State Board of Pharmacy, and with the approval of the State Board of Control, a Bureau of Professional Relations was organized in the School of Pharmacy at the University of Florida. To date the Board of Pharmacy has appropriated over \$17,000 for this work and the School of Pharmacy has given a great deal of the time of its staff as well as office space and facilities. The Bureau is directed by Perry A. Foote, Ph.D., who is Director of the School of Pharmacy and Professor of Pharmaceutical Chemistry. From November 1, 1940 to December 1942, Associate Director Jordan devoted his whole time to this work and personally contacted many physicians and pharmacists. Due to war conditions the Bureau no longer has a field representative but relies on monthly mailings.

*Objectives.* Some of the objectives of the program might be briefly reviewed: (1) To promote a better understanding between the physician and pharmacist. (2) To foster cooperation in the solution of mutual professional problems. (3) To promote better ethical pharmaceutical practice. (4) To increase the prescribing of drugs which are recognized by medical authorities and which are official in the U.S.P. and N.F. To give preference to these instead of high priced specialties. (5) To discourage "counter prescribing" and "curbstone prescribing." (6) To discourage self-medication and mass medication. (7) To encourage individualized medication.

*Publications.* To facilitate the prescribing of U.S.P. and N.F. drugs and to give Florida physicians a convenient reference to latest drug therapies advocated by medical authorities, the Accepted Florida Formulary was compiled. These formulas were approved by a committee of five members of the Florida Medical Association. Approximately 2,500 copies have been distributed free to physicians, drug stores and army hospitals in our state. The Formulary is exhibited on one hundred and fifty 3x5 cards in a steel file box. Demand has exceeded the supply so it became necessary to issue a Supplement

in booklet form. This contains a section on Military Medicine which was arrived at in conference with the Medical Staff at Camp Blanding. All new formulas must be approved by the Interrelationship Committee which has delegated Dr. John E. Maines, Jr., of Gainesville to act for it.

Monthly bulletins, 10 per year, discuss newer formulas containing vitamins, sulfra drugs, etc. The Bureau is now issuing a series of six instructive bulletins on "Hormones in Health and Disease". These are being written on request for more information on this important group of drugs. A special "Bureau Series" of abstracts of current medical literature was published for three years. Pamphlets are issued each month to further the work. About 100,000 pieces of literature are mailed each year. Requests for it come from physicians and pharmacists from almost every state. These are so numerous that it is necessary to charge \$5 per year for literature sent out of the state. As time permitted, before the war, the Bureau's staff wrote several articles for the Journal of the Florida Medical Association.

**Exhibits.** The Bureau has presented exhibits before two conventions of the Florida Medical Association and three Post-Graduate Courses for Physicians held annually in Jacksonville. Due to a smaller staff, exhibits will be given only before Florida Post-Graduate Courses during the war. Exhibits have also been given at conventions of the Florida State Pharmaceutical Association and the American Pharmaceutical Association.

**Cooperation.** In slightly more than three years the Florida Bureau of Professional Relations has gained local and national recognition as one of the leaders in this important type of work. Its success has been due to the splendid cooperation of the physicians and pharmacists in our state. For this it is most grateful. In so short a time ideal results are impossible to obtain. With the help of both professions we can solve many mutual problems outside of the field of *materia medica*. Legislative matters continually challenge us. Socialized medicine and possibly socialized pharmacy now threaten. A few minutes of thought concerning the many problems ahead leads us to the conviction that "We Have a Job To Do Together."

Respectfully submitted,  
(Signed) P. A. Foote, *Director*  
Bureau of Professional Relations,  
School of Pharmacy,  
U. of Fla.

"The Committee received the report of the Committee on Public Relations and considers one detail in the final paragraph well worth reading again: 'Because the Blue Cross plan does not cover medical fees it would seem that it now is timely for the Florida Medical Association to go on record as approving in principle non-profit voluntary medical insurance to make more complete the answer to the advocates of compulsory health insurance, to-wit: the socialization of medicine.' Your Committee has approved this report and its recommendations."

Motion made and seconded that the report be adopted. There was no discussion and the motion prevailed.

#### REPORT OF COMMITTEE ON PUBLIC RELATIONS

Since last October your committee has been cooperating with the Council on Medical Service and Public Relations of the American Medical Association. Since about that date the Council has kept this office up to date with its activities.

It is the Council's plan that the Public Relations

Committee of each state function on a state level with the Council and with the same idea that each component county medical society appoint a public relations committee to function with the state committee. The Council has placed the state committee on its mailing lists for the distribution of materials but the state committee is expected to arrange for the redistribution of such materials to the component societies.

The duties devolved on the Council by the House of Delegates are as follows:

(a) To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people; (b) to inform the constituent associations and component societies of proposed changes affecting medical care in the nation; (c) to inform constituent associations and component societies regarding the activities of the Council; (d) to investigate matters pertaining to the economic, social and similar aspects of medical care for all the people; (e) to study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates and (f) to develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association.

Therefore, it is readily seen that your Committee on Public Relations has been given definite duties and is responsible for the proper distribution to the component medical societies of all information regarding the present day threat of the socialization of medicine.

Your committee therefore urges that all county medical societies appoint an active chairman on Public Relations to whom material may be sent and by whom the county society may be informed of the progress of the work at each meeting.

There probably will be more or less expense involved in the distribution of materials received by the state committee. Just what expenses this will entail cannot at present be estimated. Nevertheless, this probably is the best means for the State Association to keep its membership adequately informed of the progress of the issues facing it today. The promoters of compulsory health insurance have gone a long way toward convincing the public that private practice has failed to provide adequate medical care for the people. We must furnish leadership and counter their arguments by showing why the private practice of medicine should continue and, in answer to their demand for prepaid medical care, we have to convince the medical profession as well as the public that if we must have prepaid medical fees that voluntary health insurance is preferable—will preserve the patient-physician relationship, will be more economical to the patient and not destroy the physician's initiative. In the past the medical profession has been slow to endorse any type of health insurance, but several state associations have endorsed some form of voluntary health insurance which has been successful only in those cases where such endorsement was followed by a like endorsement of *all* the physicians belonging to such state associations. This is all important for no voluntary insurance plan will work out in practice unless it is endorsed by the medical association and subscribed to by all of its members because the first thing an interested subscriber looks for is the name of his private physician and if he is not a member, interest is immediately lost.

During recent months the Blue Cross hospital plan was approved by the Florida Hospital Association and recommended to its members. Because the Blue Cross plan does not cover medical fees, it would seem that now is timely for the Florida Medical Association to go on record as approving in principle nonprofit voluntary medical insurance to make more complete the answer to the advocates of compulsory health insurance, to wit: the socialization of medicine. Your committee would recommend that the Board of Governors study the different plans and companies affording this type of insurance and present the result of its investigations with recommendations to the profession, not later than the 1945 meeting of the Florida Medical Association.

Respectfully submitted,  
Leigh F. Robinson, *Chairman.*

"The Committee recommends the adoption of the report of the Committee on Medical Education and Hospitals."

It was moved and seconded that the report be adopted. Motion prevailed.

#### REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Your committee has not undertaken any new activities during the past year, owing to the war effort. We realize that this is an important committee and that there is work to be done in connection with medical education and hospitals. It is not possible during these trying times to investigate Florida hospitals with a view to making recommendations.

Your committee has received communications relative to the status of certain hospitals and each communication has been answered, submitting what information was at that time available. The list of hospitals to be published in the 1944 Florida Medical Directory has been edited. The names of hospitals, sanatoriums or related institutions in Florida is headed by the following comment:

The inclusion of any institution may be taken as an indication that evidence concerning irregular or unsafe practices in that institution has not come to the attention of the Committee on Medical Education and Hospitals.

Respectfully submitted,

H. G. Holland, *Chairman*.

"The Committee received the report of the Committee on Legislation and Public Policy. It was read and approved and we suggest that the Legislative Committee study this problem and be in a position to present to the next Legislature proper corrective legislation."

It was moved and seconded that this report be adopted. Motion prevailed.

#### REPORT OF COMMITTEE ON LEGISLATION AND PUBLIC POLICY

Your Committee on Legislation and Public Policy has had rather an active year. In the 1943 session of the Florida Legislature, many bills relative to the practice of the healing arts and public health matters were introduced. Some of these, fostered by the medical profession, passed, some of our important bills failed to pass, while a number of bills detrimental to public health we succeeded in defeating.

The committee is greatly indebted to Dr. Harold D. Van Schaick of Jacksonville, chairman of the outgoing Committee on Legislation and Public Policy, he having initiated the Association's program at the beginning of the session of the Legislature. We deemed it advisable for him to stay with it, which he most generously agreed to do.

There was statewide interest in House Bill 308 relating to the appointment of members of the State Board of Health. The original bill was amended to such an extent that its authors requested that it be killed.

Senate Bill 641 became a law. It designates a time limit for the recording of medical licenses. Heretofore, the law required licenses to be recorded but set no time limit. This amendment to the Medical Practice Act should do much to prevent impostors from using fraudulent licenses. Senate Bill 639, providing for aid in the enforcement of the Medical Practice Act, and Senate Bill 640, seeking appointment of an assistant to the secretary of the State Board of Medical Examiners, both died on the calendar. The death of this latter bill was a blow to the Board of Medical Examiners who fostered it. Since the creation of the Composite Board of Medical Examiners in 1921, its members have spent their time and money freely in eradicating illegal practition-

ers from Florida and enforcing the Medical Practice Act. The fight has been a hard one which is well known and appreciated by members of our Association. Florida being a large state with a close proximity to foreign countries, whose population has increased by leaps and bounds during the last two decades, the time has arrived, if the efficient enforcement of our medical practice laws is to continue, when there must be some re-adjustments made.

The fees collected from the applicants taking the State Board examinations are about 50 per cent of the amount necessary to operate the secretary's office. This deficit has been greatly increased by the high cost of office help, material, etc. In one week's time the Secretary of the Board was subpoenaed to appear in court against illegal practitioners in three widely separated counties in the state which necessitated his being out of his office, his only means of livelihood, for nearly a week, and paying out of his own pocket the bigger part of the expenses accrued. This is only one instance of many. It was the earnest hope of the Board of Medical Examiners that it would be able to continue its work by having a law enacted whereby one of the full time salaried investigators for the State Board of Health could act as an assistant to the secretary of the Board of Medical Examiners in these various court proceedings. With the failure of this bill, as secretary of the Board of Medical Examiners, I am being forced to relinquish a work in which it has been my pleasure to serve you for over a quarter of a century.

Bills that were passed by the Legislature and became Laws provided for:

Physicians with the armed forces to be kept in good standing by the State Board of Medical Examiners.

Licenses issued by State Board of Medical Examiners to be recorded with Clerk of Circuit Court within sixty days.

Appropriation for Insulin.

University of South Florida.

State Tuberculosis Sanatorium.

Subsequent reports on venereal disease cases.

Venereal disease reports used to enforce compulsory treatment laws.

Persons rejected or deferred for military service, infected with venereal disease, must report to venereal disease clinic.

Revocation of hotel or apartment house licenses for violation of law against prostitution.

Prohibiting lewdness, assignation and prostitution.

Prohibiting compulsory prostitution.

Unlawful to live off earnings of a prostitute.

Unlawful to rent any place for purpose of prostitution.

Quarantine and treatment of persons infected with venereal disease.

State Hospital for care and treatment of persons afflicted with venereal disease.

Amending Workmen's Compensation Law for increase in employer's liability.

County Judge's courts to issue delayed birth certificates.

Aid to the blind.

Hospitalization and sick benefit system, Miami Beach.

Calhoun County tax levy for public health unit.

Optometry.

Defining trade of opticians.

Amending naturopathic law.

Creation of Board of Masseurs.

Respectfully submitted,

W. M. Rowlett, *Chairman*.

"The report of the Committee on Economics: This was brought up before the House of Delegates last year and you will find it in the published record of the House of Delegates, 1943 session. The Reference Committee received the report of the Medical Economics Committee and we wish it to be accepted as information, but that the schedule is not satisfactory and urge that the Committee continue their activities along lines which the House of Delegates has suggested in time past."

It was moved and seconded that the report be accepted as information.

Dr. Day: Does that report recommend that this fee schedule be used only as a guide?

Dr. Jones: It recommends that we act along the same lines as the House of Delegates has acted on previously. As I see it, we feel that this thing must be kept open.

There being no further discussion the motion to accept the report as information prevailed.

#### REPORT OF COMMITTEE ON MEDICAL ECONOMICS

Due to present conditions, our committee was unable to meet personally but some matters were discussed among the members by letter and phone.

The important matter before the committee this year was an attempt to revise the medical and surgical fee schedule which became effective January 1, 1943.

There have been a great many complaints throughout the state, not only by physicians and surgeons but also by many of the claim men representing the insurance companies because of many omissions and discrepancies of the schedule.

Through the suggestion of the Fee Schedule Committee of the Florida Association of Industrial Surgeons and many other interested parties, Dr. Peek appointed, in October, a special committee to attempt to revise, clarify and make more understandable the present fee schedule.

This special committee consisted of: Drs. F. A. Vogt, A. M. Bidwell, F. L. Fort, Lloyd J. Netto, W. McL. Shaw.

This committee was to meet at the George Washington Hotel in Jacksonville, October 31, 1943 with Mr. Rountree and other members of the Commission.

In the meantime, this committee, mainly through the efforts of Dr. A. M. Bidwell, outlined certain changes and suggestions for the schedule.

At the meeting in Jacksonville on October 31, these suggestions and changes were read to Mr. Walter Rountree, the director of compensation, and were freely discussed by representatives of the various insurance companies and the members of the committee.\*

Respectfully submitted

F. A. Vogt, Chairman.

*\*(The balance of this report which contains voluminous details, is omitted. Copies of up-to-date fee schedules may be obtained from the Florida Industrial Commission, Bisbee Building, Jacksonville 2, Florida.)*

It was moved and seconded that a vote of thanks be extended the Economics Committee for the amount of work they had accomplished. Motion prevailed.

#### REPORT OF REFERENCE COMMITTEE No. 3

Dr. Shaler Richardson, chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the recommendations of that committee.

"The Committee approves the report of the Committee on War Participation and Procurement and Assignment, and commends the chairman, Dr. Edward Jelks, for his untiring efforts in this work."

It was moved and seconded that the report be adopted. Motion prevailed.

#### REPORT OF COMMITTEE ON WAR PARTICIPATION AND PROCUREMENT AND ASSIGNMENT

The War Participation and Procurement and Assignment Committees, whose personnel is the same, and whose functions are interlocking have been primarily concerned during the past year in:

First, reclassifying physicians in order to procure the remaining few who might be available for military service, and to retain the medical manpower needed for care of civilians.

Second, aiding in securing quotas of medical officers for hospitals.

Third, cooperating in the relocating of physicians from out of the state into localities where there is an acute shortage of doctors.

Failures and not accomplishments would be reported to you today if it were not for the ardent and unselfish work of the members of the state and county committees. They have traveled any distance to attend meetings; interviewed individuals and institutions; recommended classification of doctors; carried out extensive correspondence; and in many other ways served in this work which is so important to the Florida Medical Association.

The ratio of doctors to population is 1 to 2,185. Although this ratio is below that considered to be adequate, namely: 1 to 1,500, the service rendered by physicians in civilian practice has been such that no major complaints of shortages have reached the Procurement and Assignment office. Requests for medical help have been received from distress areas. This need for medical care is caused by an abnormal increase in population due to some war activity, rather than to the loss of physicians entering the military services. It appears that in Florida, under present military and national conditions, about all of the doctors that can be spared for the Army and the Navy have already been made available and are on active duty or have been found to be physically disqualified for commissions. This latter group totals 120.

Upon reports from hospitals and recommendations by the State Committee of Procurement and Assignment, the Central Committee in Washington has established quotas of house officers for hospitals. The basis of the allocations was the number of house officers which hospitals had in 1940.

In order to improve the existing method for relocation of physicians, Dr. Leigh F. Robinson, Medical Director of the Civilian Defense Council, has established in conjunction with the State Board of Medical Examiners, The State Board of Health, The Florida Medical Association and the Procurement and Assignment Service, a clearly defined procedure by which certificates may be granted to out-of-state doctors allowing them to practice temporarily in certain localities when such certificates are requested by the county medical society. So far, there have been 18 certificates granted.

In December 1943 we had the assistance of a representative from the Central Office in Washington who spent several days in going over the roster of Florida physicians and helping to establish the status of every doctor. Just previous to her visit we had made a state wide survey of medical need and medical manpower. This was studied in detail at a meeting of the state committee in November 1943. We are now in the process of making the changes that are necessary to bring the roster up to date.

For the coming year there are no visible sources from which doctors can be obtained in large numbers to relieve the pressure upon civilian practitioners. Since the beginning of the war only twenty-one physicians have been returned from the services. Of future graduates from medical schools 80 per cent or more will not be available for civilian practice until the close of the war. With the normal rate of incapacity and death among the profession the probabilities are that the sum total of medical manpower will be less at the end than at the beginning of the next twelve months.

Therefore, thorough cooperation between the doctors and the people must prevail if we are to prevent unnecessary suffering from lack of medical care. Not only to participate in this coordination, but also to inform all concerned of the medical service problem can be a function of the War Participation Committee which will result in benefit to the sick and to the profession. Another activity of this committee is to help the doctors when they return from the services. Honest endeavors by all "to carry through" in this time of great emergency should develop a consciousness of interdependence and confidence capable of producing in the future a better medical world.

Respectfully submitted,  
Edward Jelks, *Chairman.*

"The Committee approves the report of the Council and recommends that the report be adopted and published."

It was moved and seconded that the report be adopted and published. Motion prevailed.

#### REPORT OF COUNCIL

As was reported last year, due to the changed conditions throughout the state, which have caused each and every doctor to work considerably longer hours than ever before, there have been fewer and fewer meetings and the problems for investigation by the Council have been nonexistent.

From the reports submitted the chief activities have been centered around assisting in the location of doctors by temporary license in various counties in the state where the need was found.

There have been no District Meetings this year. We have reports from all the councilors which will be condensed for publication in the Journal.

Respectfully submitted,  
Lloyd J. Netto, *Chairman.*

"The Committee recommends that the report of the Board of Governors be approved."

It was moved and seconded that the report be adopted and published. Motion prevailed.

#### REPORT OF BOARD OF GOVERNORS

The first meeting of the Board of Governors was held in Jacksonville at 1:30 p. m., April 16, 1943, just after the close of the annual convention. After careful study and consideration, a working budget was approved for the ensuing year.

Dr. Lawrence T. Galphin of Fernandina was elected an honorary member of the Association on recommendation of the Nassau County Medical Society. Dr. Ralph E. Balch of Melbourne was proposed for honorary membership by the Brevard County Medical Society. No action was taken, as Dr. Balch was practicing as a relocated physician under a temporary certificate. The local society was advised that Dr. Balch would be extended the courtesy of attending meetings of the Florida Medical Association, but the By-Laws of our Association do not provide for membership of persons not holding regular licenses to practice medicine in the state. Dr. William T. Langley of Sanford was elected an honorary member of the Association on recommendation of the Seminole County Medical Society.

The second meeting of the Board of Governors was held in Jacksonville, Sunday, October 31, 1943. Dr. Rufus Judson Pearson, Sr., was elected to honorary membership of the Association on recommendation of the Dade County Medical Society.

The House of Delegates in April, 1943, had referred a portion of the annual report of the Committee on Legislation and Public Policy to the Board of Governors for action. The recommendation, briefly, was "the president to select one member of his county society to act as a liaison between the Legislative Committee and the members of the society." The Board members feel that the essence of the recommendation is good and they suggested that each member of the Legislative Committee should contact the county medical societies in his medical district and secure a list of senators and representatives who are to be in the Legislature.

The following interpretation of Resolution (112), page 10 of the By-Laws, and Resolution (114), adopted by the House of Delegates, April, 1943, was adopted as a working basis until the next meeting of the House of Delegates:

A member who on or after January 1, 1942 entered military service or the United States Public Health Service for the duration of the present emergency (if not paid before he entered) will not be required to pay the annual \$10.00 Association dues for the Calendar year in which he entered service. No member will be required to pay Association dues for the calendar year in which his service in the emergency terminates.

The invitation by the Pinellas County Medical Society to hold the 1944 annual meeting of the Association in St. Petersburg was accepted. The official dates for the annual meeting were set for April 13 and 14, 1944. The schedule for the 1944 annual meeting as shown in the official program, was adopted.

A communication dated October 20, 1943, from J. W. Holloway, Jr., acting secretary, Council on Medical Service and Public Relations of the American Medical Association, requested that an existing committee or a new committee be created to function with the Council on a state level in connection with medical service and public relations. Our regular committee on Public Relations, of which Dr. Leigh F. Robinson is chairman, was designated and the A. M. A. notified.

Dr. W. C. Thomas, chairman of the Association's Committee on Maternal Welfare, and Dr. George L. Cook, chairman of the Committee on Child Health, attended the meeting and lead a general discussion on the Florida plan for the emergency maternity and infant care program presented by the U. S. Children's Bureau through the State Board of Health. The Board went on record as not approving the principle involved, but action would be governed by individual county societies. This action was taken for the following reasons which were submitted by Dr. Thomas, chairman of the Committee on Maternal Welfare:

1. The plan for maternal and pediatric care to wives and infants of enlisted men makes payments direct to physicians.
2. It encourages the development of a poor quality of obstetric-pediatric care—a condition which always follows the operation of a regimented program.
3. It establishes a precedent for further extension of governmental intrusion into the private practice of medicine.
4. It opens the door to governmental medical service for ALL, without economic distinction or determination of need.
5. It makes no provision for the abnormal obstetrical case—either during pregnancy, delivery or puerperium—other than consultation service.
6. A different fee schedule has been set up in different states.

The third meeting was held Thursday, January 6, 1944. A resolution was presented by Dr. Leigh F. Robinson, chairman of the Division of Health and Housing of the State Defense Council, pertaining to temporary licenses for relocated physicians. The procedure as outlined by Hon. Tom Watson, Attorney General, was approved. The text of the resolution and details of the procedure may be found in the March issue of the Florida Medical Journal.

Respectfully submitted,  
Robert D. Ferguson, *Chairman.*

REPORT OF COMMITTEE ON NECROLOGY

During the past fiscal year our Association lost by death the members whose names are listed below:

Frank T. Barker, Tampa  
Ray W. Blackmar, Jacksonville  
Chester C. Box, Crestview  
Clifton P. Bullard, Miami  
Lyman L. Bunker, Fernandina  
Julian C. Chandler, Tampa  
H. Franklin Davis, Miami  
Julian F. Gardner, Winter Park  
Burton T. Gordon, Pompano  
Charles G. Griffin, Miami  
John A. Herring, St. Petersburg  
James M. Hoffman, Pensacola  
William J. Holton, Plant City  
Joel W. Hood, Ocala  
Charles L. Jennings, Jacksonville  
Herbert A. Johnson, Palatka  
Emil Lustig, St. Petersburg  
James R. McEachern, Tampa  
Millen A. Nickle, Clearwater  
Robert G. Nobles, Pensacola  
Henry E. Palmer, Tallahassee  
James D. Pasco, Jacksonville  
J. Harris Pierpont, Pensacola  
Raymond B. Ramage, Jacksonville  
Thomas M. Rivers, Kissimmee  
Edmund P. Shelby, Venice  
William R. Warren, Key West  
John M. Whitfield, Panama City  
William E. Whitlock, High Springs  
Meyer Wigdor, Miami Beach  
Cecil H. Wilson, Bartow

When possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence, in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,  
Gerry R. Holden, *Chairman.*

On motion duly made, seconded and carried, the House of Delegates adjourned, sine die.

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## SCIENTIFIC ASSEMBLIES

### FIRST SCIENTIFIC ASSEMBLY

The Scientific Assembly convened at 8:00 p. m., Thursday, April 13, in the Assembly Room of the Princess Martha Hotel, with Dr. Herbert E. White presiding.

The following papers were read; numbers three and four were discussed:

1. "Fundus Changes in Arterial Hypertension," Walter I. Lillie, Professor of Ophthalmology, Temple University, Philadelphia.
2. This paper withdrawn.
3. "Penicillin" (Exhibits: a. Growing Penicillin; b. Effects on Staphylococci), Captain Millard B. White, Director of Laboratories, MacDill Field, Tampa.

4. "Primary Atypical Pneumonia; Analysis of 150 Cases," Captain Morris B. Guthrie, Chief of Section on Respiratory Diseases, MacDill Field, Tampa.

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## SECOND SCIENTIFIC ASSEMBLY

The Second Scientific Assembly was held Friday, April 14, at 10:30 a. m., Dr. Herbert E. White presiding.

The following papers were read; numbers five and six were discussed.

5. "Refrigeration Anesthesia of the Extremities; Its Application, Use and Case Reports," Duncan T. McEwan, Orlando.

6. "Gynecologic Problems Beginning at Forty," Lt. Comdr. Carroll J. Fairo, Diplomate, American Board of Obstetrics and Gynecology; Instructor, Obstetrics and Gynecology, University of Cincinnati, Coast Guard Training Station, Palm Beach.

7. "The Challenge of Tuberculosis to the Physician," Henry G. Sweany, Director of Research and Laboratories, Chicago.

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## REGISTRATION

The total registration during the seventy-first annual meeting of the Florida Medical Association, held in St. Petersburg, April 13 and 14, was 506; members, 276; visiting doctors, 80; allied groups, 3; exhibitors, 76; Woman's Auxiliary, 71.

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ARTHUR L. WALTERS, M.D...D-45.....	Miami Beach

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JOHN A. SIMMONS, M.D...AL-45.....	Arcadia
FERDINAND A. VOGT, M.D...D-46.....	Miami

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Sixth—EDGAR WATSON, M.D...6-45.....	Lakeland
Seventh—WILLIAM Y. SAYAD, M.D...7-45.....	W. P. Beach
Eighth—E. M. HENDRICKS, M.D...8-46.....	Ft. Lauderdale

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SHALER RICHARDSON, M.D., Vice Chm.....	Jacksonville
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CAROL C. WEBB, M.D.....	Pensacola

### A. M. A. HOUSE OF DELEGATES

EDWARD JELKS, M.D., Delegate.....	Jacksonville
O. O. FEASTER, M.D., Alternate.....	St. Petersburg
(Terms expire Dec. 31, 1944)	
HOMER L. PEARSON, M.D., Delegate.....	Miami
GEORGE C. TILLMAN, M.D., Alternate.....	Gainesville
(Terms expire Dec. 31, 1945)	

\*Alternate for member in Armed Services.



JOHN R. BOLING, OUR PRESIDENT

Dr. John R. Boling of Tampa was inducted into the presidency of the Florida Medical Association at its Seventy-First Annual Meeting, held in St. Petersburg, April 13 and 14, 1944.

Dr. Boling was born in South Carolina in the year 1894. He received his medical training at the Atlanta Medical College (now Emory University), from which he was graduated in 1915. His internship was served at Hamot Hospital in Erie, Pa., following which he was a member of the armed forces for two years during World War I. He studied surgery in Columbia, S. C., as assistant to Dr. George Bunch.

In 1925, Dr. Boling moved to Florida, locating at Bradenton. He practiced in that city until the fall of 1929, when he opened an office in Tampa. He has long been prominent in the State Association, having served as a member of the Board of Governors, councilor, first vice president, and president-elect.

Dr. Boling is a member of the American Medical Association, a past president of the Hillsborough County Medical Society; a Fellow of the American College of Surgeons, and certified by the American Board of Surgery. He is Director of Surgery of St. Joseph's Hospital in Tampa. He is also a thirty-second degree Mason, a Shriner, and a member of the Tampa Rotary Club. Dr. Boling and his wife, Mary Ethel Boling, have two sons, John Radford, Jr., and Davis, and one daughter, Catherine.

The Association is fortunate in having at its helm a man who is capable, energetic and willing to put his best efforts into the work of the ensuing year.

## From Our President

### ST. PETERSBURG MEETING

The efforts of those responsible for the meeting of the Association in St. Petersburg were well rewarded. The attendance was excellent; more than five hundred registered. Although the entire program was shortened because of the war, it was well arranged and handled. The scientific papers were exceptionally well prepared, and the essayists should have been gratified with the interest shown. The atmosphere throughout was more serious than usual. At all of the sessions the attendance approached 100 per cent, a record which differs considerably from that of sessions in the past. Those who were fortunate enough to be able to leave their work and be present were amply repaid. The meeting was well worth while, not only because of the scientific program, but also because of the opportunity to renew old friendships and to form new ones.

The place of next year's meeting has not yet been decided, but it is well for the members of the Association to begin planning now to attend and to take an active part. It is your Association. Help make it a good one.

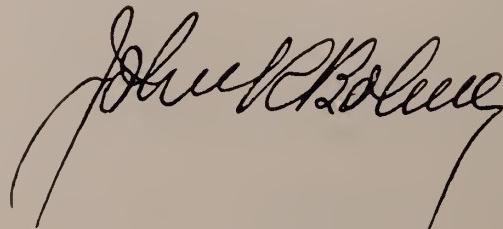
The result of the election of officers will meet with warm approval throughout the state. Every physician elected is widely known and able. Knowing that Dr. Shaler Richardson will follow me next year will make me try hard to have a successful administration. With Dr. Robert McIver as secretary and treasurer, the task will be easier. This column is the idea of Dr. Homer Pearson, the newly elected editor of the Journal. No doubt, he will also have some good ideas.

### COMMITTEES

The work of the Association is done by various committees. There are twenty-two standing committees, and others may be appointed during the year by the president. The chairman and members of each committee are not selected at random, nor haphazardly. Every section of the state is represented, and the members are chosen after much thought and careful consideration. Each physician is selected because it is believed that he is peculiarly fitted for the particular work assigned to his committee and can be depended on to do his best.

<sup>1</sup>I realize, of course, that because of the shortage of physicians every member of the Association is overworked. Nevertheless, the Association must carry on, and its work must be done. It is definitely an honor to be appointed on a committee; so accept membership thereon as such.

Let me urge you who are chairmen to get the work of your respective committees under way at once and not wait until the year is nearly gone before you start. Begin to prepare now for the report you will present next spring to the House of Delegates.



## The Journal of The Florida Medical Association

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Jacksonville 1, Florida

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## NEW EDITOR ASSUMES OFFICE

An old established custom was broken at the annual election of officers held April 14 in St. Petersburg, when Dr. Homer L. Pearson of Miami was elected editor of the Association's Journal. For the past thirty years, the offices of secretary, treasurer and editor of the Journal have been held jointly by one doctor.

At the forty-first annual meeting of the Association, held in Orlando, it was decided to publish monthly a state medical journal, and Dr. Graham E. Henson of Jacksonville, the newly elected secretary-treasurer, was made editor. The first issue of the Journal made its appearance in July, 1914. Dr. Henson served for eleven years.

At the 1925 annual convention, Dr. Shaler Richardson of Jacksonville was elected secretary, treasurer and editor of the Journal. He held these offices for nineteen years, when, at the last convention, he was made president-elect.

The circulation of the Journal and the activities of the State Association have increased steadily for a number of years. Those who were instrumental in bringing about this change are hopeful that the innovation will be beneficial. Dr. Pearson, the new editor, in assuming the responsibility for the Journal, will leave Dr. Robert B. McIver of Jacksonville more time to devote to the offices of secretary and treasurer.

## Board of Past Presidents

H. MARSHALL TAYLOR, M.D., 1923, Chm.	<i>Jacksonville</i>
WALTER C. JONES, M.D., 1941, Secy.	<i>Miami</i>
ROBERT H. McGINNIS, M.D., 1915	<i>Jacksonville</i>
FREDERICK J. WALTER, M.D., 1918	<i>San Diego, Calif.</i>
WILLIAM E. ROSS, M.D., 1919	<i>Jacksonville</i>
JOHN C. VINSON, M.D., 1924	<i>Tampa</i>
JOHN S. McEWAN, M.D., 1925	<i>Orlando</i>
II. MASON SMITH, M.D., 1926	<i>Tampa</i>
JOHN A. SIMMONS, M.D., 1927	<i>Arcadia</i>
FREDERICK J. WAAS, M.D., 1928	<i>Jacksonville</i>
HENRY C. DOZIER, M.D., 1929	<i>Ocala</i>
JULIUS C. DAVIS, M.D., 1930	<i>Quincy</i>
GERRY R. HOLDEN, M.D., 1932	<i>Jacksonville</i>
WILLIAM M. ROWLETT, M.D., 1933	<i>Tampa</i>
HOMER L. PEARSON, M.D., 1934	<i>Miami</i>
HERBERT L. BRYANS, M.D., 1935	<i>Pensacola</i>
ORION O. FEASTER, M.D., 1936	<i>St. Petersburg</i>
EDWARD JELKS, M.D., 1937	<i>Jacksonville</i>
W. HENRY SPIERS, M.D., 1938	<i>Orlando</i>
LEIGH F. ROBINSON, M.D., 1939	<i>Ft. Lauderdale</i>
J. SAM TURBERVILLE, M.D., 1940	<i>Century</i>
GILBERT S. OSINCUP, M.D., 1942	<i>Orlando</i>
EUGENE G. PEAK, M.D., 1943	<i>Ocala</i>

## HERE WE GO AGAIN

For Shaler Richardson to be elected president-elect of our Association is a fine thing for the Association, but it is not so good for the Journal. When you remove from the editorship of a journal the person who has guided it through troublesome seas for nineteen years, and put in his place one who is relatively inexperienced in such matters, it is like removing the pilot from a large ocean liner and replacing him with a fishing boat captain. All we can say is "hold your hats, fellows, here we go again."

So if you will have patience and sympathy with us, we will do our best until Shaler gets through being president and then perhaps we can get him to take the job back. We can only promise to give you the best journal we can, and that can be accomplished only with the help and cooperation of you, the members of our Association. Please let us have your suggestions and criticisms. Read your Journal.—H. L. P.



## ASSOCIATION'S ANNUAL MEETING

The seventy-first annual meeting of the Florida Medical Association was held in St. Petersburg, April 13 and 14, 1944. The registration totaled 506, of which number 276 were members of the Association, 80 were visiting doctors, 76 were representatives of exhibiting firms, 3 were from allied groups and 71 were of the Woman's Auxiliary. The number attending the Association dinner was 226.

The membership attendance this year was 276, last year in Jacksonville, 203, and the year before in Hollywood, 434. Eighty visiting physicians registered this year. At the meeting in Jacksonville last year, specialty groups did not hold their annual meetings at the time of the convention, which undoubtedly affected the attendance. Considering that more than 30 per cent of our members are with the armed forces, and that many physicians at home who would ordinarily have attended the convention were unable to leave their practice, this year's registration was as large as could be expected. The proceedings of the annual meeting, including the list of registrants, appear on the foregoing pages of this Journal.

The facilities of the Princess Martha Hotel were at the disposal of the doctors and their guests, and every courtesy was extended by Mr. A. L. Manning, the manager, and his staff.

Owing to war conditions, the meeting was limited to two half days and one evening, with specialty groups occupying an extra forenoon, when six separate meetings were held simultaneously.

There were forty technical exhibits, supervised by 76 representatives of exhibiting firms. The exhibitors made a real contribution to the convention and the doctors were generous in their expression of appreciation.

The convention was a great success despite the many handicaps and hardships we are having now. The general and scientific sessions were fully attended. Our visiting speakers were the finest, and our other essayists of the best. Many of them were doctors in military service, who were well received by those who heard them.

The House of Delegates adopted a resolution approving the action of the Hospital Association in establishing the Blue Cross in Florida. This plan is in effect in many states and is working successfully. It affords hospital insurance at rates much lower than those of commercial companies, and the plan should receive the active support of all our members.

The House of Delegates further instructed the appointment of a special committee to study the various forms of health insurance which have been adopted by other state and county medical associations with the idea of presenting a workable plan for the approval of our Association.

It is the duty of every member of this Association to familiarize himself with these and other problems of organized medicine so that we

can intelligently and unitedly combat the present grave threat of federal regimentation.



## GRADUATE SHORT COURSE

JUNE 19-24

Dr. T. Z. Cason, chairman of the Committee on Medical Postgraduate Course, announces the program for the 1944 Graduate Short Course. Owing to curtailed traveling facilities, it was considered advisable to hold the meeting in Jacksonville again this year.

Increased emphasis is being placed on post-war medicine, as evidenced by the addition of twelve lectures on postwar medicine, surgery and public health. The names of the instructors who will deliver these lectures are not announced inasmuch as the assignments have not been made at this date. The Committee has been assured that these instructors will be leaders in their fields.

The Committee is anxious to have due notice given to all physicians in the armed services that they are invited to attend this year's lectures. Particular attention is directed to the fact that there will be two lectures each evening. The high standard of previous lectures is assured.

## FACULTY THIS YEAR

**MEDICINE**—Dr. Eugene A. Stead, Jr., Professor of Medicine, Emory University, Atlanta, Ga.

**PEDIATRICS**—Dr. Samuel F. Ravelin, Dean of the Southern Pediatric Seminar, Saluda, N. C.

**VENEREAL DISEASES**—To be supplied.

*The above lectures will be held on Monday, Tuesday and Wednesday.*

**OBSTETRICS**—Dr. Oren Moore, Charlotte, N. C.  
*To be given Wednesday, Thursday and Friday.*

**SURGERY**—Dr. R. L. Sanders, Associate Professor of Surgery, University of Tennessee, Memphis, Tenn.

**GYNECOLOGY**—Dr. Clayton T. Beecham, Assistant Professor of Obstetrics and Gynecology, Temple University, Philadelphia, Pa.

*To be given Thursday, Friday and Saturday.*

**POSTWAR MEDICINE, SURGERY, PUBLIC HEALTH**—To be supplied.

Physicians should take advantage of the educational opportunities offered by advertisers in this Journal. Large sums of money are expended to disseminate information on the best products, through these advertisements and through literature which may be had on request. Doctors are requested to contact advertising firms and express appreciation for their interest and cooperation.

Request the literature which is offered; complete and send in the coupons which appear in these advertisements.

### HOSPITAL SERVICE PLAN

The organization meeting of the Florida Hospital Service Corporation was held in Jacksonville, Tuesday, May 16. It is a nonprofit organization designed to provide low cost group hospitalization for residents of Florida. Dr. Walter C. Jones of Miami was elected first vice president. Doctors elected to the Board of Directors were Dr. John R. Boling of Tampa, Dr. Edward Jelks of Jacksonville, and Dr. Walter C. Jones of Miami.

The newly elected president of the Florida Hospital Service Corporation is Mr. W. E. Arnold of Jacksonville. The state director and secretary-treasurer is Mr. H. F. Cross, whose headquarters are in Jacksonville.

### STATE NEWS ITEMS

**WANTED** — Reliable physician-surgeon to purchase offices of the late Dr. J. W. Alsobrook of Plant City. Unusual opportunity for the right physician. Full information may be obtained from Mrs. J. W. Alsobrook, 507 N. Evers Street, Plant City, Fla.

Dr. Joseph B. Kollar of Vero Beach was recently appointed a member of the State Board of Medical Examiners to succeed Dr. J. E. Crump of Winter Haven. The appointment was made by Governor Spessard Holland the latter part of April.

Dr. Shaler Richardson of Jacksonville announced recently that Dr. Walton Wall will be associated with him in the practice of ophthalmology. For the past three years Dr. Wall has been resident surgeon at the Eye and Ear Infirmary, New York City.

Dr. W. C. Page of Cocoa was named medical director of the Eugene Wuesthoff Memorial Hospital by the trustees of the hospital in April.

The annual conference on tuberculosis of the Florida Tuberculosis and Health Association will be held in Jacksonville, June 6 and 7. All sessions will be held at the Seminole Hotel. A number of talented speakers will appear on the program. All members of the Florida Medical Association are cordially invited to attend.

The National Naval Medical Center of Bethesda, Maryland, is endeavoring to collect for its archives a complete set of commissions issued to Naval medical officers, and signed by past presidents of the United States.

There is a small nidus now at the Center and it is hoped to be able to build this up to completion. Through the Navy Department Library and the National Archives a few more have been located. Various libraries or individuals may have in their possession such old commissions and would be willing to turn them over to the Center. If such are found and the owners are so generous, there could be no more fitting enshrinement of them than their use for this purpose.



Dr. Rosa L. Sullivay of Pensacola will visit clinics in Miami and go to Chicago to attend the meetings of the National Women's Medical Association and the American Medical Association in June.



Dr. Henry Hanson of Jacksonville, State Health Officer for Florida, was decorated by the Cuban Government for meritorious service in public health work in the Western Hemisphere on May 17. The medal was presented by President Batista. On this occasion, Dr. Hanson represented the Pan-American Sanitary Bureau at the dedication of Cuba's new public health building. The Bureau is composed of the national and state health departments of North, South and Central America.

### BIRTHS AND DEATHS

#### BIRTHS

Dr. and Mrs. K. K. Waering of Jacksonville Beach announce the birth of a son, Eugene Kjellesvig, on April 22.

Dr. and Mrs. Saul H. Kaplan of Miami Beach announce the birth of a daughter, Ellen Jane, on May 2.

#### DEATHS

Dr. John W. Alsobrook of Plant City died on April 10.

Dr. John C. Ellis of Panama City died on April 19.

Dr. Chapman Dykes of Haines City died May 3, while in military service.

### JOHN WALTER ALSO BROOK

Dr. John W. Alsobrook of Plant City, a Life Member of the Florida Medical Association, died on April 20.

Born at LaFayette, Chambers County, Ala., on March 28, 1876, he was the son of John N. and Alice Lenore Alsobrook. John N. Alsobrook was one of a family of thirteen sons, eleven of whom were young soldiers of the Confederacy in the War Between the States, in which one of the number lost his life. Dr. Alsobrook's father, who was born in Tolbery County, Georgia, had seven sons, four of whom were in military service in World War I, including Dr. Alsobrook, who gained the rank of major in the Medical Corps of the Army, stationed at Newport News, Va.

Dr. Alsobrook's academic education was received in LaFayette College, Ala. Later he entered the medical department of Vanderbilt University at Nashville, from which he was graduated in 1904. In that same year he began his practice in Plant City, where he continued his able and successful professional work up to the time of his death, except for the period of his service in the United States Army. His popularity and professional ability were reflected in the scope and character of his practice, for he was one of the most prominent physicians and surgeons in Hillsborough County. He maintained private hospital rooms for the handling of surgical cases exclusively.

He was a Fellow of the American Medical Association, a Life Member of the Florida Medical Association, past president of the Hillsborough County Medical Society, a member of the National Association of Military Surgeons, local surgeon for the Atlantic Coast Line railway, and surgeon-in-chief for the Coronet Phosphate Co. He was the first president of the Plant City Kiwanis Club, a Mason, a Knight of Pythias, and a member of the Methodist church.

On June 15, 1905, Dr. Alsobrook was married to Miss Margaret Kilpatrick, who was born and reared in Mississippi. The widow and one daughter, Mrs. William F. Jibb, are the immediate survivors.

During the funeral services, all business houses of Plant City were closed in tribute to one who, for two score years, had been active in the medical, civic, religious and educational life of the community.

### WILLIAM EUGENE WHITLOCK

Dr. William E. Whitlock of High Springs died in Meridian, Mississippi, on April 5, at the age of 57.

A native of Lake City, S. C., Dr. Whitlock was the son of Harvey L. and Lula Pate Whitlock. He received his preliminary education at Clemson College, S. C., and then entered the Medical College of South Carolina, from which he was graduated in 1910. He was licensed in Florida in 1912, and located at Fort White. In 1922 he moved to High Springs where he practiced up to the time of his death.

In 1910 Dr. Whitlock was married to Miss Hilmer Gradick of Charleston, S. C.

Dr. Whitlock was active in the civic life of his community, having served as mayor of High Springs. He was commander of the local American Legion post, and served as district and state commander of the American Legion before being named national vice commander at St. Louis in 1935. He was sent by the president, with others, to investigate the hurricane tragedy near Key West some years ago.

He had an outstanding record in World War I, participating in the St. Mihiel advance, the Meuse-Argonne offensive and other engagements. Among other awards, he received the Purple Heart, the Croix de Guerre and the Military Cross.

Besides his widow, he is survived by seven children, Mrs. Hilmer W. Horne, San Diego; Mrs. Mary W. Gregory and Eula Whitlock, High Springs; Capt. W. E. Whitlock, Camp Bowie, Texas; L. G. Whitlock, High Springs; Sgt. Forrest G. Whitlock, Drew Field; Seaman 2/c Paul P. Whitlock, Portsmouth, Va. He is also survived by six grandchildren, his mother, Mrs. Lula P. Whitlock, four sisters and three brothers, all of Lake City, S. C.

COMPONENT COUNTY SOCIETIES

DADE

The regular meeting of the Dade County Medical Society was held Tuesday evening, April 4, in the library of the Jackson Memorial Hospital, Miami. Dr. Wiley M. Sams, president, presided. Dr. C. Larimore Perry read an excellent paper on "The Surgical Management of Cystocele," which he illustrated with slides and motion pictures. The paper was discussed by Drs. George Ferre, Maurice Rose and Walter C. Jones.

DUVAL

The April meeting of the Duval County Medical Society was held on the evening of April 4 at St. Luke's Hospital, Jacksonville. Dr. J. G. Lyerly, the president, was in the chair. A sound film was presented, called "Psychiatry in Action." This film, produced in England, was shown through the courtesy of the office of the British Vice Consul.

MARION

At the April meeting of this society, which was held at the Harrington Hotel, Ocala, on the 20th, Dr. E. G. Peek, immediate past president of the State Association, and Dr. R. D. Ferguson, former chairman of the Board of Governors and delegate to the state convention, reported on the annual meeting of the Association, held in St. Petersburg on April 13 and 14. They mentioned that Dr. Thomas H. Wallis, a member of the society for fifteen years, had been made an Honorary Member of the Association.

PINELLAS

At the meeting of the Pinellas County Medical Society held at the Detroit Hotel, St. Petersburg, on Friday, May 5, the following scientific program was presented: "Caudal Anesthesia," Dr. M. Q. Kintner; "Army Aviation Medicine," Dr. Bill Meyer; and "The Need of Cattle Inoculation for Undulant Fever Control," Dr. A. J. Bieker.

BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review as expedient.*

SYNOPSIS OF NEUROPSYCHIATRY. By Lowell S. Selling, Sc. M., M. D., Ph. D., D. P. H., Director, Psychopathic Clinic, Recorder's Court, Detroit, Mich. Fabrikoid. Price, \$5.00. Pp. 500. St. Louis: C. V. Mosby Company, 1944.

ADVERTISERS' NOTES

PRICE REDUCTION

This is to announce a second reduction in the price of UNICAP VITAMINS to your patients.

In February, 1943, the price was reduced 20%. On April 1, 1944, it was reduced again—this time approximately 25%.

The formula has not been changed with this latest price reduction.

The Upjohn Company.



B. AND L. SHOW

For the second time, Bausch & Lomb Optical Co. of Rochester, New York, has produced an elaborate show, "Dawn's Early Light," for its employees and their families. In it, and through various mediums, the story of the company's wartime activities and importance was told, a subtle boost was given to employee morale, and a liberal sprinkling of humor and music was included for entertainment.

To accommodate the better than 21,000 spectators, the Eastman Theater in Rochester was engaged for three days, and two performances a day were given. The times of the afternoon performances were varied to allow different shifts to attend.

Outstanding was the presentation of the principles of optics in a ballet number entitled "Bright Miracle." Refraction, reflection, divergence, and convergence were demonstrated by light rays passing through several lens forms, while as a finale, fluorescent rays traced their paths through a pentaprism and dispersed into the spectrum when they entered and left a prism, to provide a colorful close.

Also featured was the Bausch & Lomb Chorus of 110 voices, singing a choral number entitled, "Forward Free Men," written especially for and dedicated to that organization by Domenico Savino.

Speaker of the production was Paul Manning, recently returned war correspondent with the Army Air Forces. Richard Himber's Spotlight Band provided a tuneful and humorous interlude, and a dramatic interpretation of the war's implications was given by Irene Wicker of "Singing Lady" fame.

President M. Herbert Eisenhart of Bausch & Lomb gave point to the whole performance when he said, "The crucial period of this war is still before us. Our forces everywhere are now on the aggressive and they need our help—I am sure we will all do our duty."



BETTER PICTURES BECOME POSSIBLE

Taking better pictures in either dim or bright light will be made possible for camera fans by a new method of reducing light reflections in camera lenses, H. R. Moulton, assistant research director of the American Optical Company, announced recently.

Comparing the performance of untreated lenses and those treated by the new technic, he reported that the latter would possess an increased light transmission ranging from over 6 per cent for a one-lens camera to over 50 per cent for a four-lens camera.

Moulton said that the gain in light transmission would enable a photographer to take better pictures in dim light, and in bright light would reduce undesirable light images such as "ghosts" and out-of-focus images.

Untreated ordinary glass, he explained, transmits about 92 per cent of light, the remaining 8 per cent being lost through surface reflections. This loss of light, he said, is even greater in untreated ultra-modern camera lenses because of the special types of glass used in their manufacture.

The new method of saving this lost light, he added, consists of a special surface treatment which at present is being used solely for war purposes.

**WOMAN'S AUXILIARY**

TO THE  
FLORIDA MEDICAL ASSOCIATION, INC.  
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Mrs. P. J. MANSON, First Vice President.....Miami  
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Mrs. LEIGH F. ROBINSON, Historian.....Ft. Lauderdale  
Mrs. F. W. KRUEGER, Parliamentarian.....Jacksonville

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Mrs. JAMES C. GRIFFIN, District "C".....Tampa  
Mrs. LEIGH F. ROBINSON, District "D".....Ft. Lauderdale

**THE ANNUAL CONVENTION**

Officers elected at the recent State Convention held in St. Petersburg, April 13 and 14, with headquarters at the Princess Martha Hotel, were as follows: Mrs. W. C. Williams, West Palm Beach, president; Mrs. P. J. Manson, Miami, first vice president; Mrs. J. E. Maines, Gainesville, second vice president; Mrs. J. W. Hayes, Jacksonville, secretary-treasurer; Mrs. Leigh F. Robinson, Ft. Lauderdale, historian; Mrs. F. W. Krueger, Jacksonville, parliamentarian.

Standing committees: Mrs. S. M. Copeland, press and publicity; Mrs. Rupert Stovall, public relations; Mrs. C. H. Murphy, finance; Mrs. Charles F. Henley, legislation; Mrs. George C. Tillman, student loan; Mrs. W. J. Barge, archives; Mrs. H. A. Leavitt, exhibit; Mrs. Gordon H. Ira, Hygeia; Mrs. C. E. Royce, bulletin; Mrs. P. J. Manson, program; Mrs. J. E. Maines, organization.

Mrs. F. W. Krueger, president, presided at the business session. Rev. H. V. Kahlenberg, pastor of Trinity Lutheran Church, St. Petersburg, gave the invocation. Mrs. Arnold Anderson delivered the address of welcome and Mrs. J. W. Hayes gave the response.

Interesting reports were heard from all over the state which showed that every county auxiliary had been active during the year. Of outstanding interest were the reports of the defense and public relations activities over the state.

Mrs. Gordon H. Ira conducted a very impressive memorial service for Mrs. Walter A. Weed, who had been active in the Auxiliary for a number of years. She was held in the highest es-

teem by all who knew her. The Auxiliary has lost one of its most beloved members and extends deepest sympathy to her bereaved family.

The report of the president, Mrs. F. W. Krueger, was read and accepted with a rising vote of thanks from the Auxiliary for the many accomplishments achieved during her two years' administration. Mrs. W. J. Barge, past president, presented Mrs. Krueger with a past president's pin as a token of appreciation for her untiring services to the Auxiliary.

One of the highlights of the convention was the luncheon at the Army and Navy Club. Beautiful spring flowers adorned each table and corsages of unusual design and beauty were presented to each lady in attendance. Mrs. Arnold Anderson and her committee had charge of arrangements, and members of the hostess Auxiliary succeeded in creating an atmosphere of generous hospitality and good will for those attending the convention. St. Petersburg will long be remembered as the place where one of the most successful medical conventions was ever held.

Delegates elected to attend the National Convention were Mrs. W. J. Barge and Mrs. Frank Wilson; alternates, Mrs. Gordon H. Ira and Mrs. J. W. Hayes.

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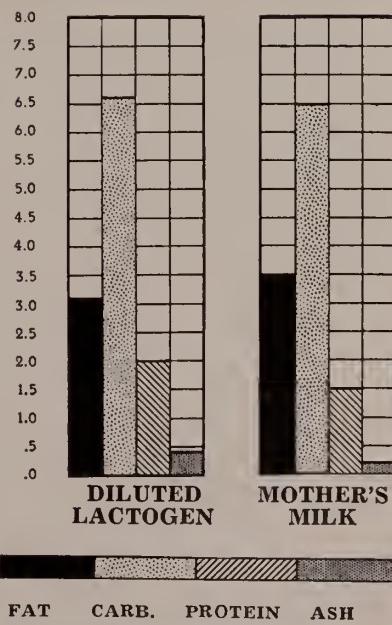
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Florida Medical Districts:			
A—Northwest .....	Courtland D. Whitaker, Marianna	Stewart Thompson, Jacksonville.....	Tallahassee, Postponed
B—Northeast .....	L. Y. Dyrenforth, Jacksonville....	" " "	Ocala, Postponed
C—Southwest .....	Edgar Watson, Lakeland.....	" " "	Sarasota, Postponed
D—Southeast .....	William Y. Sayad, W. Palm Beach..	" " "	Miami, Postponed
American Medical Association.....	James E. Paullin, Atlanta, Ga.....	Olin West, Chicago .....	Chicago, June 12-16, 1944
Southern Medical Association.....	James A. Ryan, Covington, Ky.....	Mr. C. P. Loranz, Birmingham.....	St. Louis, Nov. 13-16, 1944
Alabama Medical Association.....	H. B. Searcy, Tuscaloosa.....	D. L. Cannon, Montgomery.....	
Georgia, Medical Assn. of.....	W. A. Selman, Atlanta.....	E. D. Shanks, Atlanta.....	
Florida—			
Section, Am. College Phys.....	Meredith Mallory, Orlando.....	Rollin D. Thompson, Orlando.....	Gainesville, June 8, 1944
Basic Science Exam. Board .....	M. W. Emmel, D.V.M., Gainesville	J. F. Conn, Ph.D., DeLand.....	
Dental Society, State.....	E. C. Lunsford, D.D.S., Miami .....	H. L. Cartee, D.D.S., Miami .....	
Derm. and Syph., Soc. of .....	J. Frank Wilson, Jacksonville.....	Wesley W. Wilson, Tampa.....	Postponed
East Coast Medical Association.....	T. C. Kenaston, Cocoa.....	I. M. Hay, Melbourne.....	
Hospital Association.....	Mr. Dewitt Miller, Orlando .....	Mr. R. G. Bowden, Orlando .....	
Hospital Service Corporation .....	Mr. W. E. Arnold, Jacksonville .....	Mr. H. A. Cross, Jacksonville .....	
Industrial Surgeons, Assn. of .....	Kenneth A. Morris, Jacksonville .....	A. M. Bidwell, Tampa .....	
Medical Examining Board .....	George S. McClellan, Pompano .....	W. M. Rowlett, Tampa .....	Jacksonville, June 26-27, 1944
Medical Postgraduate Course .....	Turner Z. Cason, Jacksonville .....	Chairman.....	Jacksonville, June 19-24, 1944
Nurses Association, State.....	Mrs. C. Lindabury, Miami Beach .....	Miss Madalee Hazel, Jacksonville .....	
Ophthal. & Otol., Soc. of .....	Shaler Richardson, Jacksonville .....	C. E. Dunaway, Miami .....	
Pathological Society.....	L. Y. Dyrenforth, Jacksonville .....	Iva C. Youmans, Miami .....	
Pediatric Society.....	Ludo von Meyenbug, Daytona B.	Robert Blessing, Ft. Lauderdale .....	
Pharmaceutical Association, State.....	Mr. H. B. Douglas, Bonifay .....	Mr. R. Q. Richards, Ft. Myers .....	Miami, To Be Announced
Public Health Association .....	A. P. Black, Gainesville .....	E. M. L'Engle, Jacksonville .....	
Radiological Society .....	Walter A. Weed, Orlando .....	Chas. M. Gray, Tampa .....	
Railway Surgeons' Association .....	Frank D. Gray, Orlando .....	W. C. Page, Cocoa .....	
Tuberculosis & Health Assn.....	Mrs. M. M. Ebert, Lake Wales .....	Mrs. May Pynchon, Jacksonville .....	Postponed for Duration
Chattahoochee Valley Med. Assn.....	Herbert E. White, St. Augustine .....	Robert B. McIver, Jacksonville .....	Jacksonville, June 6, 7, 1944
Gulf Coast Clinical Society.....	G. G. Oswalt, Mobile, Ala.....	C. L. Rutherford, Mobile, Ala.....	Postponed
S.E. Sec., Am. Cong. Phys. Ther.....	John J. McGuire, Pensacola .....	Kenneth Phillips, Miami .....	Postponed
Southeastern Surgical Congress.....	Alton Ochsner, New Orleans .....	B. T. Beasley, Atlanta .....	Postponed
Suwannee River Medical Society .....	L. J. Arnold, Jr., Lake City .....	H. S. Howell, Lake City .....	

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				Total	Paid	
Bay	Don S. Fraser, M.D. 456 Grace Ave. Panama City	J. O. Barfield, M.D. County Health Unit Panama City		13	100%	
Escambia *Santa Rosa	J. K. Turberville, M.D. Century	Lee Sharp, M.D. 24 W. Chase St. Pensacola	2nd Tuesday 8:00 P.M.	46	44	A-1-45 C. D. Whitaker, M.D. Marianna
Franklin-Gulf	T. A. Meriwether, M.D. Wewahitchka	J. R. Norton, M.D. Port St. Joe	3rd Tuesday Odd Months	6	100%	
Jackson *Calhoun	C. D. Whitaker, M.D. Burton Bld., Marianna	C. A. Adams, Jr., M.D. Marianna	2nd Tuesday 7:30 P.M.	12	100%	
Walton-Okalooosa	E. L. Huggins, M.D. DeFuniak Springs	A. G. Williams, M.D. Lakewood	3rd Thursday 8:00 P.M.	6	100%	
A Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Vernon		6	100%	
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Leon-Gadsden- Liberty-Wakulla- Jefferson	John L. Williams, M.D. Tallahassee	L. L. Dozier, M.D. Midyette-Moor Bldg. Tallahassee	Quarterly 8:00 P.M.	39	38	A-2-46 G. Wilmet Brown, M.D. Tallahassee
Madison-Suwannee	Eustace Long, M.D. Madison	E. D. Thorpe, M.D. Madison		9	100%	
Taylor *Dixie, Lafayette	W. J. Baker, M.D. Foley	C. A. O'Quinn, M.D. Perry	Last Friday 8:00 P.M.	4	100%	
Alachua *Bradford, Gilchrist, Union	W. E. Murphree, M.D. 1270 Seminole Ave. Gainesville	J. H. Thomas, M.D. 749 E. Main St. N. Gainesville	2nd Wednesday 7:30 P.M.	28	25	
Duval *Clay	J. G. Lyerly, M.D. 514 Greenleaf Bldg. Jacksonville 2	O. E. Harrell, M.D. 712 Laura St. Jacksonville 2	1st Tuesday 8:15 P.M.	197	196	B-3-45 L. Y. Dyrenforth, M.D. Jacksonville
Marion *Levy	Robbins Nettles, M.D. Ocala	B. F. Drake, M.D. Professional Bldg. Ocala	3rd Thursday 12:30 P.M.	26	100%	
Nassau	W. A. Brewster, M.D. Callahan	Geo. A. Dame, M.D. Fernandina	2nd Wednesday 8:00 P.M.	7	6	
Putnam	Bernard E. Kane, M.D. Crescent City	Edward W. Ford, M.D. Crescent City	2nd Tuesday Even Months 7:00 P.M.	9	100%	
St. Johns	G. Walter Potter, M.D. East Coast Hospital St. Augustine	Charles C. Grace, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P.M.	12	100%	
Brevard	I. F. Bean, M.D. Melbourne	I. K. Hicks, M.D. Melbourne	3rd Wednesday	11	9	
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Seminole	Samuel Puleston, M.D. Brumley-Puleston Bldg. Sanford	Leland H. Dame, M.D. Co. Health Unit Sanford	2nd Tuesday 5:30 P.M.	13	100%	
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Polk	W. F. Peacock, M.D. Barnett Embry Bldg. Bartow	Edgar Watson, M.D. Box 1021 Lakeland	2nd Wednesday 1:00 P.M.	60	54	
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Dade	Wiley M. Sams, M.D. 305 Ingraham Bldg. Miami, 32	J. J. Nugent, M.D. 701 Huntington Bldg. Miami, 32	1st Tuesday 8:30 P.M.	350	336	D-8-46 E. M. Hendricks, M.D. Ft. Lauderdale
Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	Julio J. DePoo, M.D. 419 Eaton St., Key West	1st Sunday 9:00 P.M.	5	2	

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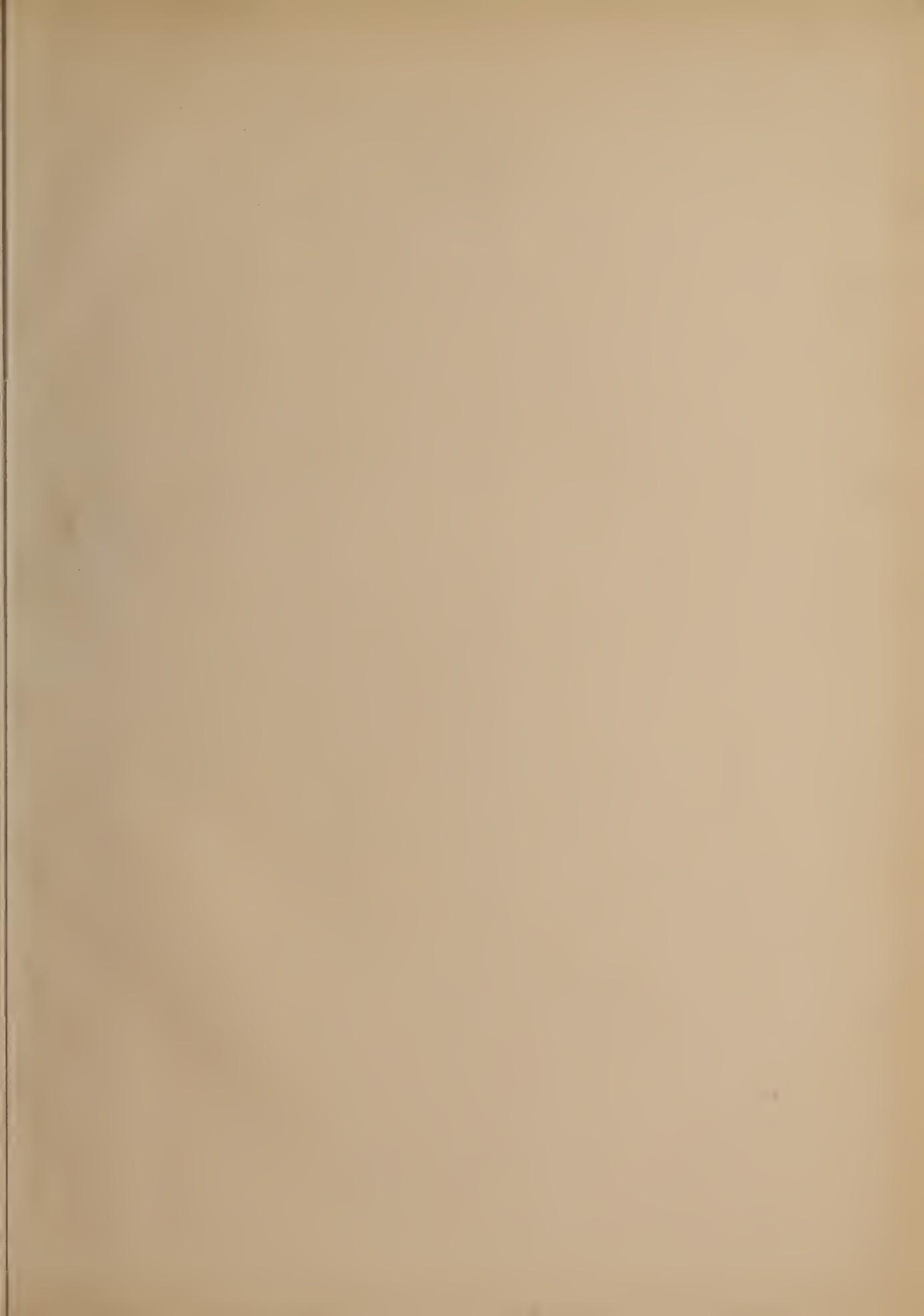
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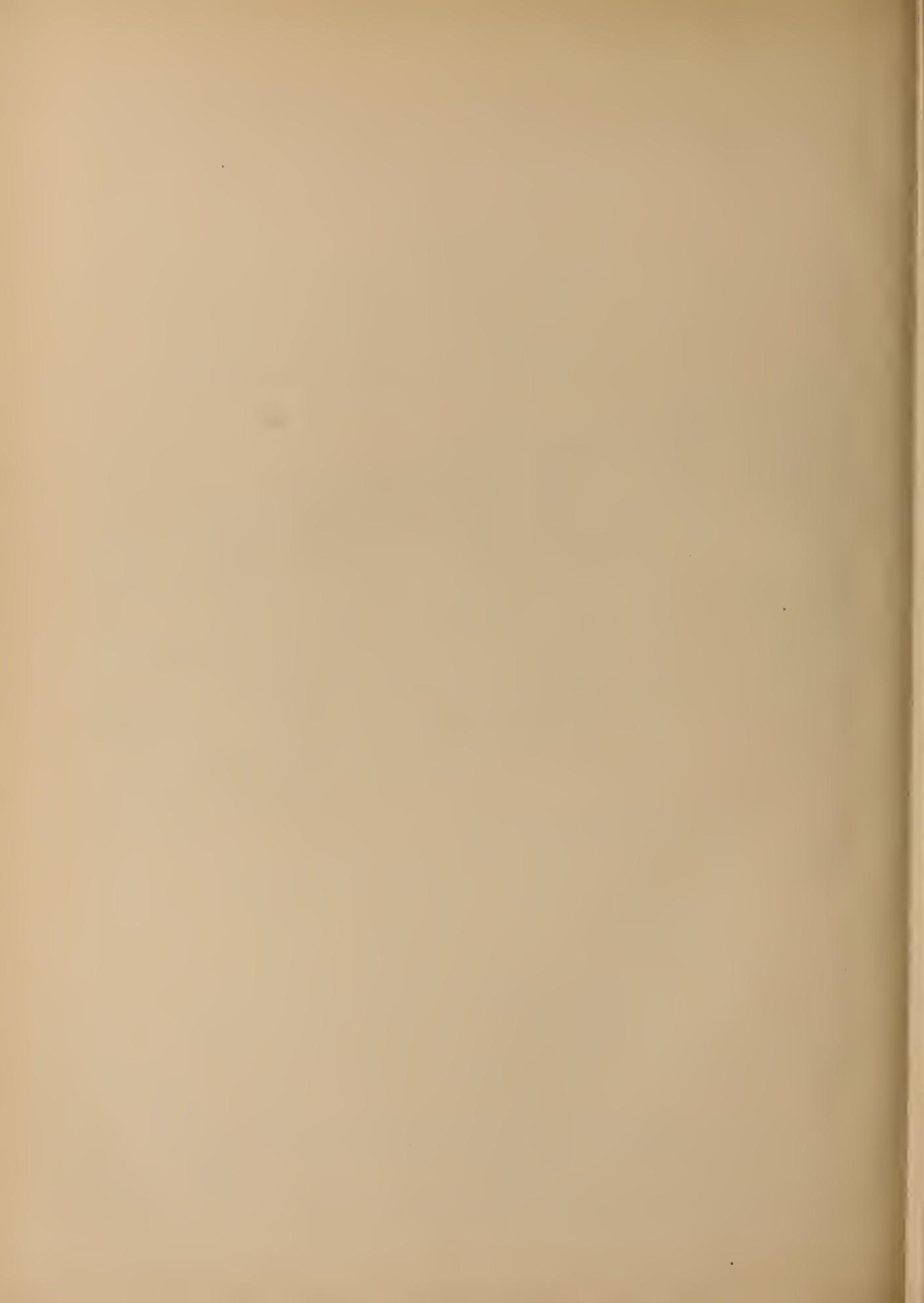
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RENEWAL BE OBTAINED FROM THE LIBRARY.

AUG 29 1946

